

Aspiration Pneumonia: Aspirating Everything from Soup to Nuts

A WEBINAR PRESENTED ON APRIL 26, 2023



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Presented By



- **Natalie Negro, MPH, BSN, RN, CCDS**, CDI manager at Penn Medicine in Philadelphia, Pennsylvania, provides education and support to encourage growth and development of an effective CDI department, follows metrics and key performance indicators, and collaborates with providers and other stakeholders to ensure the success of Penn Medicine. In her previous role of quality analyst/auditor for Penn Medicine, Negro focused on auditing CDI specialists' work across the health system to ensure data integrity and consistency while providing reports for management based in quality and department metrics. Negro is a member of the ACDIS Resource Library Committee and a contributing member of the ACDIS Leadership Council. She is an amateur detective at heart and enjoys true crime podcasts and escape rooms, as well as spending time with her husband, 2-year-old, and 6-month-old twins.

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Presented By



- **Jisha Chacko, MSN, RN**, is a CDI specialist at Penn Medicine in Philadelphia, Pennsylvania. Chacko has been a registered nurse for 17 years and spent 14 years of that time as a bedside nurse at Temple University's neurosurgery/orthopedic postop care unit. The transition to CDI was an opportunity for Chacko to use her clinical knowledge and experience on a whole new level. She started the CDI program at Penn Medicine and in her current role reviews inpatient records daily and collaborates with providers, coding professionals, and other healthcare team members to facilitate comprehensive medical record documentation. She has also taken the opportunity to oversee special assignments for the department, such as clinical validations and educational sessions. Chacko has a son and a goldendoodle puppy she adores, and her hobbies include taking long walks with her dog and gardening.

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Agenda

- Learning outcomes
- Clinical overview
- CDI and coding considerations
 - DRG impact
 - Quality impact
 - Clinical validation and denials
 - Review of guidelines and Coding Clinic® guidance
- Summary

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Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
 - Define and recognize the clinical aspects of aspiration pneumonia
 - Explain the impact of aspiration pneumonia coding on reimbursement and quality
 - Demonstrate understanding of the coding and CDI guidelines and considerations related to aspiration pneumonia

CLINICAL OVERVIEW

Definitions, Clinical Indicators, Treatments, and Complications

Clinical Content

1. What is Pneumonia?
2. What is Aspiration Pneumonia/Pneumonitis?
3. What are the Risk Factors and Signs/Symptoms?
4. How is it Diagnosed?
5. How is it Treated/Monitored?
6. Complications of Aspiration Pneumonia/Pneumonitis

What Is Pneumonia?

- Pneumonia - lung infection that inflames the air sacs in one or both lungs. A variety of organisms, including bacteria, viruses, and fungi, can cause pneumonia.
- Types of Pneumonia
 - Aspiration pneumonia
 - Community-acquired pneumonia (CAP)
 - Healthcare-associated pneumonia (HCAP)
 - Hospital-acquired pneumonia (HAP)
 - Ventilator-associated pneumonia (VAP)
 - Gram-negative pneumonia
 - Staphylococcal (MRSA/MSSA) pneumonia
 - COVID pneumonia

What Is Aspiration Pneumonia/Pneumonitis?

- Aspiration pneumonia is a “pulmonary infection from large-volume aspiration of an infection source,” while aspiration pneumonitis is “a lung injury from acute inflammation that occurs after chemical burns in the airways and lung parenchyma.” (Son et al., 2017)
- Aspiration pneumonia is a dominant form of community-acquired and healthcare-associated pneumonia, and a leading cause of death among aging populations.
- Aspiration pneumonia may result when food, saliva, liquids, or vomitus is aspirated into the bronchi or lungs.
- Aspiration of gastric contents will cause a chemical pneumonitis (e.g. Mendelson's syndrome) because the gastric contents are usually sterile, but their acidity results in the rapid development of inflammation in the lungs.

Son, Y. G., Shin, J., & Ryu, H. G. (2017). Pneumonitis and pneumonia after aspiration. *Journal of Dental Anesthesia and Pain Medicine*, 17(1), 1. <https://doi.org/10.17245/jdapm.2017.17.1.1>

Aspiration Pneumonia/Pneumonitis (cont.)

Aspiration Pneumonia

- Lung infection
- Caused by: Virus, bacteria, fungus, parasites, others
- Leads to anaerobic bacterial infection

Aspiration Pneumonitis

- Lung inflammation
- Caused by: Chemicals, toxins, drugs, radiation, aspiration
- Can be acute and/or chronic, can progress to secondary infection

Risk Factors

- Patients with reduced consciousness (use of sedative drugs, alcohol or drug use, anesthesia) can compromise the cough reflex and glottic closure
- Dysphagia from neurologic conditions
- Disorders of the upper GI tract including esophageal disease, surgery involving the upper airways or esophagus, and GERD
- Tracheostomy, endotracheal intubation, head and neck cancer, bronchoscopy, upper endoscopy, and nasogastric feeding
- Recent vomiting; presence of NG tube
- Poor dental hygiene is also associated with increased risk of aspiration pneumonia
- NH resident; debilitated, bed-confined patients
- Cardiac arrest has been associated with a particularly high incidence of pneumonia, presumably due to loss of consciousness as well as aspiration of oropharyngeal and gastric contents in the context of cardiopulmonary resuscitation, bag-valve mask ventilation, and emergent intubation
- Seizure disorders

Klompas, M. (n.d.). *Aspiration pneumonia in adults*. UpToDate. Retrieved March 30, 2023, from <https://www.uptodate.com/contents/aspiration-pneumonia-in-adults>

Signs and Symptoms

- Fever/chills
- Shortness of breath (dyspnea) or wheezing
- Coughing up blood or pus
- Chest pain
- Bad breath
- Extreme tiredness
- Exam reveals: Rales, rhonchi, bronchial breath sounds, decreased breath sounds, pleural rub, dullness to percussion

Sanivarapu, R., & Gibson, J. (2022, December 9). *Aspiration pneumonia*. National Library of Medicine. Retrieved March 30, 2023, from <https://www.ncbi.nlm.nih.gov/books/NBK470459/>

Diagnosis

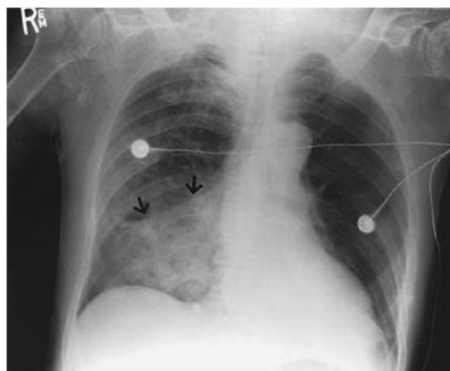
- Clinical history, risk factors, and presence of acute symptoms
- Possible witnessed aspiration event (though this is more likely with aspiration pneumonitis)
- Bronchoscopy: May be helpful to determine organisms and is indicated with food aspiration events; oral contents, food particles, pepsin, or bile in the trachea-bronchial tree or bronchoalveolar lavage fluid may be present
- Chest x-ray: May see infiltrates most often in the RLL
- CT scan: May be more accurate for detecting pneumonia
- Swallow study: A study may be done to help determine if a patient is at risk for aspiration, but it is not definitive

Cleveland Clinic. (2021, October 7). *Aspiration pneumonia: What it is, causes, diagnosis, treatment*. Cleveland Clinic. Retrieved March 30, 2023, from <https://my.clevelandclinic.org/health/diseases/21954-aspiration-pneumonia>

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Diagnosis (cont.)



Anteroposterior Radiograph of the Chest, Showing Air-Space Consolidation (Arrows) in the Right Lower Lobe in a Patient with the aspiration pneumonitis.

Marik, P. (2001, March 1). *Aspiration pneumonitis and aspiration pneumonia*. The New England Journal of Medicine. Retrieved March 30, 2023, from <https://www.nejm.org/doi/full/10.1056/NEJM200103013440908>

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Treatment and Monitoring

- A full course of antibiotic treatment lasting 5-10 days helps to confirm a diagnosis of pneumonia
- CAP TX: Zithromax, Rocephin, Levaquin, Doxycycline; if the patient has severe CAP, multiple broad-spectrum antibiotics are recommended
- HAP TX: Vancomycin, cefepime, cefazolin, ceftazidime, Cipro, others
- Aspiration: Clindamycin, Flagyl, Zosyn
- Supplemental Oxygen
- Rescue BIPAP
- Mechanical Ventilation
- Repeat Chest X-ray
- Follow Up Speech and Swallow Exams
- Aspiration Precautions and Diet (ex. thin liquid)

Note: Patients who aspirate gastric contents are considered have aspiration pneumonitis, and usually resolution of symptoms within 24 – 48 hrs and require only supportive treatment, without antibiotics. But almost all patients in the hospital setting treated with antibiotics

Treatment and Monitoring

- Antibiotics are initiated immediately even though they are not required in aspiration pneumonitis to prevent the progression of the disease.
- The choice of antibiotics for community-acquired aspiration pneumonia are ampicillin-sulbactam or a combination of metronidazole and amoxicillin.
- In patients with penicillin allergy, clindamycin is preferred.
- In hospital-acquired aspiration pneumonia, antibiotics are needed that cover resistant gram-negative bacteria and *S. aureus*, so the use of a combination of vancomycin and piperacillin-tazobactam is most widely used.
- Once the culture results are obtained, the antibiotic regimen should be narrowed to be organism-specific.

Treatment and Monitoring

Table 1. Antibiotic Treatment of Aspiration Pneumonia.*

Drug	Dose, Schedule, and Route of Administration
Ampicillin-sulbactam	1.5–3 g every 6 hr, intravenous
Amoxicillin-clavulanate	875 mg twice daily, oral
Piperacillin-tazobactam	4.5 g every 8 hr or 3.375 g every 6 hr, intravenous
Ceftriaxone	1–2 g once daily, intravenous
Cefepime	2 g every 8–12 hr, intravenous
Ertapenem	1 g once daily, intravenous
Imipenem	500 mg every 6 hr or 1 g every 8 hr, intravenous
Meropenem	1 g every 8 hr, intravenous
Levofloxacin	750 mg once daily, intravenous or oral
Moxifloxacin	400 mg once daily, intravenous or oral
Clindamycin	450 mg three or four times daily, oral; or 600 mg every 8 hr, intravenous
Gentamicin or tobramycin†	5–7 mg/kg once daily, intravenous
Amikacin†	15 mg/kg once daily, intravenous
Colistin‡	9 million IU per day in two or three divided doses, intravenous
Vancomycin†	15 mg/kg every 12 hr, intravenous
Linezolid	600 mg every 12 hr, intravenous or oral

Mandell, L., & Niederman, M. (2019, February 14). *Aspiration pneumonia*. The New England Journal of Medicine. Retrieved March 30, 2023, from <https://www.nejm.org/doi/10.1056/NEJMra1714562>

Prognosis

The prognosis is dependent on the patient age and other comorbidities. However, despite optimal treatment, death rates of 11-30% have been reported. Even those who survive have a prolonged recovery, and repeated admissions are common.

Potential Complications With Aspiration Pneumonia

- ARDS
- Empyema
- Lung abscess
- Spread of infection to the bloodstream (bacteremia)
- Spread of infection to other areas of the body
- Respiratory failure
- Sepsis
- Shock
- Death

Sanivarapu, R., & Gibson, J. (2022, December 9). *Aspiration pneumonia*. National Library of Medicine. Retrieved March 30, 2023, from <https://www.ncbi.nlm.nih.gov/books/NBK470459/>

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CDI and Coding Considerations

DRG and Quality, Clinical Validation Denials, and Coding Clinic Review

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CDI and Coding Considerations

- Causation is Key
 - The suspected or confirmed organism causing the pneumonia can change both the code assignment and the DRG
- Suspicion is OK
 - If, by the time of discharge, the provider is still documenting the type of pneumonia as “suspected,” “probably,” “likely,” etc., it is okay to code the added specificity
- Examples of Causation Documentation
 - “Pneumonia due to aspiration”
 - “Aspiration Pneumonia”
 - “Pneumonia 2/2 aspiration”
- Complexity Counts
 - “Simple” pneumonias (ex. Unspecified pneumonia) are assigned to the lower-weighted DRG triad 193-195
 - “Complex” pneumonias (ex. Aspiration pneumonia!) are assigned to the higher-weighted DRG triad 177-179

Eramo, L. (2019, April). *Of Viral Importance*. For the Record. Retrieved March 29, 2023, from <https://www.fortherecordmag.com/archives/0419p18.shtml>

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MS-DRG Impact Case Study: Principal Diagnosis

- A 60 yo F currently undergoing RT for SCC of the glottis/supraglottis s/p supracricoid laryngectomy and neck dissection with a recent history of RSV bronchiolitis was admitted with SOB and chest pain, found to have “multifocal pneumonia.” The patient is also severely malnourished, with a BMI of 18.87.
- CT chest showed: Dependent mucus in the trachea, and mucoid impaction in left lower and right lower lobe bronchioles, with the left lower lobe predominant. Peripheral to this mucoid debris, in the left lower lobe and right middle lobe there are now peribronchial vascular consolidations, in addition to previously demonstrated tree-in-bud nodularity and groundglass opacities consistent with progression of aspiration pneumonia, with the left lower lobe predominant. Early stages of a similar process are now apparent in the right lower lobe.
- Labs: RSV+
- Patient was treated with IV Linezolid, Zosyn, and Azithromycin.
- CDI queried for the type of pneumonia.
- The provider documented in the Discharge Summary: “Likely superimposed bacterial aspiration pneumonia on top of RSV pneumonitis, now doing better on IV antibiotics.”

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MS-DRG Impact Case Study: Principal Diagnosis

	Pre-CDI Query	Post-CDI Query
MS-DRG	193 Simple Pneumonia and Pleurisy w/ MCC	177 Respiratory Infections and Inflammations w/ MCC
Relative Weight	1.2987	1.7799
GLOS	4	5.2
SOI	2	2
ROM	2	2
Estimated Reimbursement*	\$12,987	\$17,799

*Using a \$10,000 Base Rate ²³

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MS-DRG Impact Case Study: Secondary Diagnosis

- A 67 yo F with a PMH of dementia, CHF, and CVA with residual dysphagia was admitted with an acute HFpEF exacerbation.
- CXR showed: Diffuse interstitial and patchy airspace opacities, most likely pulmonary edema with possible component of pneumonia, noting prominent right lower lobe patchy opacities.
- Patient was treated with IV Azithromycin and Ceftriaxone.
- Speech Language Pathology was consulted.
- Provider documented in the H&P: “-No signs of sepsis for now, placed on aspiration precautions, supp O2 PRN. F/u bedside swallow and advance diet (NPO exc meds for now for possible aspiration, also keep NPO from midnight for possible IR tomorrow).”
- CDI queried for aspiration pneumonia.
- The provider documented in the Discharge Summary: “Pneumonia (probably due to aspiration).”

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MS-DRG Impact Case Study: Secondary Diagnosis

	Pre-CDI Query	Post-CDI Query
MS-DRG	293 Heart Failure and Shock w/o CC/MCC	291 Heart Failure and Shock w/ MCC
Relative Weight	0.5603	1.2798
GLOS	2.1	3.9
SOI	1	3
ROM	1	3
Estimated Reimbursement*	\$5,603	\$12,798

*Using a \$10,000 Base Rate

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Quality Impact

Vizient Complication

- Vizient contains a database where hospitals can compare their quality performance to peers
- Aspiration Pneumonia is a Vizient Complication
- POA Y and W do not count; only POA N
- Codes included are J690 Pneumonitis due to inhalation of food and vomit, J691 Pneumonitis due to inhalation of oils and essences, and J698 Pneumonitis due to inhalation of other solids and liquids

CMS Hospital Readmission Reduction Program (HRRP)

- Established under Section 1886(q) of the Social Security Act
- Compares readmission rate of like hospitals
- Maximum payment reduction is 3%
- Pneumonia (as PDx or SDx on sepsis cases) is one of the included measures
- Paused as part of payment reduction for FY 2023 due to COVID
- However, CMS is still reporting hospitals' pneumonia readmission results to provide transparency

CMS Hospital Value Based Purchasing

- Established under Section 1886(o) of the Social Security Act
- Incentive payments based on hospital's Total Performance Scores (TPS)
- One measure in the TPS is Hospital 30-Day, All Cause, Risk-Standardized Mortality Rate following hospitalizations for pneumonia
- Paused for FY 2023 due to COVID

Centers for Medicare and Medicaid. (n.d.). *Hospital Readmissions Reduction Program Frequently Asked Questions Fiscal Year 2023*. Retrieved March 30, 2023, from https://qualitynet.cms.gov/files/62eadf8625af60001694522d?filename=FY2023_HRRP_FAQs.pdf
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Clinical Validation Denial Example Case: Insurance Denial

The coding of aspiration pneumonitis is not supported by the medical documentation. There are no bronchoscopy results showing erythema or evidence of particulates, or chest imaging show findings consistent with aspiration. Although this patient had a prior history of aspiration, there is no objective clinical evidence to support this diagnosis during the current admission. Additionally, the appeal letter confirms that the patient's respiratory issues were secondary to pneumonia. The diagnosis of aspiration pneumonitis is not substantiated.

Clinical Validation Denial Example Case: CDI Review

- Topic: **Aspiration Pneumonia (Sdx)**
- Decision: Disagree with insurance company. **Aspiration pneumonia is clinically valid.**
- Notes:
 - Risk Factors: **Lesch-Nyhan syndrome, CP w/ quadriplegia s/p PEG tube and recurrent aspiration pneumonias**, recent admission 1 month ago for coronavirus URI
 - Criteria Met:
 - Supporting Imaging: *3/20 Chest X-ray*: Cluster of interval more conspicuous faint opacities in the left basilar and lower lung zone. This may be **compatible with pneumonia**, of uncertain etiology, noting that this patient had presumed inflammatory opacities in the same lung zone on the prior radiographs from 2/8/2020 and 12/18/2019
 - Supporting Assessments: Physical exam was s/f **decreased breath sounds R>L.**
 - Treatment and Monitoring: **azithromycin** 500 mg in NSS 250 mL IVPB, **aztreonam** 1 g in NSS 50 mL IVPB, **levoFLOxacin** 750mg in D5W 150mL IVPB, c/w **pulmonary toilet** with albuterol/hypertonic saline nebs three times a day, **glycopyrrolate** 2.5 mg three times a day as per home regimen

Clinical Validation Denial Example Case: CDI Review (cont.)

- Provider Documentation:**
H&P Attending Note: "CXR is read as faint opacities in L lung that may be **compatible with pneumonia** and **procalcitonin is slightly elevated** at 0.87"
Discharge Document: "Suspected that his **acute presentation was due to aspiration pneumonia**. He was also tested for COVID-19 with the result pending at the time of discharge. He was transitioned to levofloxacin for **presumed aspiration pneumonia** and discharged to complete a **7-day course** (3/21-3/27)."
- Additional Comments:** This patient met criteria Pneumonia (aspiration PNA) based on **chest x-ray**. Physician documented "**acute presentation was due to aspiration pneumonia**." Patient has **CP (which affects the sensory and peripheral nervous system)**, and prior aspiration pneumonitis. Patient also has a **PEG due to impaired swallowing** (such as occurs after neurologic diseases) which provides his nutrition. Aspiration pneumonitis and pneumonia are caused by inhaling toxic substances, usually gastric contents, into the lungs. **Chest x-ray, CT and barium esophagography are gold standard tests** for the diagnosis of aspiration pneumonitis. **Bronchoscopy is an invasive procedure used if emergently necessary** for diagnosis and treatment. The medical team (**Attending and Resident**) had clearly documented the diagnosis of presumed aspiration pneumonia in the discharge document with supportive documentation.

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Coding Clinic Review-Aspiration Pneumonia and Sepsis

Sepsis due to gram-negative aspiration pneumonia

Question: A patient was discharged with the following diagnoses: **1. sepsis secondary to aspiration pneumonia, 2. aspiration pneumonia secondary to probable gram-negative bacteria**. Both diagnoses were present on admission. **Should this be coded as sepsis due to gram-negative pneumonia?**

Answer: **When sepsis and aspiration pneumonia are related and present on admission, the sepsis should be sequenced as the principal diagnosis.** Assign code A41.50, Gram-negative sepsis, unspecified, as the principal diagnosis. Codes J15.6, Pneumonia due to other Gramnegative bacteria, and J69.0, Pneumonitis due to inhalation of food and vomit, should be assigned as additional diagnoses. The pneumonia is a gram-negative bacterial aspiration pneumonia and is the localized infection that has led to sepsis. Code J69.0 is assigned to capture aspiration pneumonia.

The coding professional should follow guideline 1.C.1.d.4, Sepsis and severe sepsis with a localized infection, which states, "if the reason for admission is both sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, a code(s) for the underlying systemic infection should be assigned first and the code for the localized infection should be assigned as a secondary diagnosis."

Sepsis due to aspiration pneumonia

Question: When the provider documents "**sepsis due to aspiration pneumonia**," is a code for the **sepsis, or the aspiration pneumonia assigned as the principal diagnosis?**

Answer: Assign code A41.9 **Sepsis, unspecified organism, as the principal diagnosis.** Codes J18.9, Pneumonia, unspecified organism, and J69.0, Pneumonitis due to inhalation of food and vomit, should be assigned as additional diagnoses. Sepsis indicates infection and the body's response to it. Aspiration pneumonia may be just from the direct effect of inhaled material, such as a chemical effect, or it may involve infection; however, for sepsis to result, it would need to involve an infectious pneumonia. **Therefore, codes J18.9 and J69.0 are both needed to show the presence of a localized infection (pneumonia and unspecified organism) as well as pneumonia due to aspiration.** When sepsis and aspiration pneumonia are related (i.e., sepsis due to aspiration pneumonia or sepsis related to aspiration pneumonia) and present on admission, sepsis should be sequenced as the principal diagnosis.

ICD-10-CM/PCS Coding Clinic, Second Quarter 2020, pp. 28-29

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Coding Clinic Review-Aspiration Pneumonia and Other Respiratory Conditions



Coding Clinic: Aspiration pneumonia and pneumonia due to COVID-19

Question: If a patient has both aspiration pneumonia and pneumonia due to COVID-19, may code J12.89, Other viral pneumonia, be assigned with code J69.0, Pneumonitis due to inhalation of food and vomit? There is an Excludes1 note at category J12, Viral pneumonia, not elsewhere classified, that excludes pneumonia not otherwise specified (J69.0). (4/28/2020; revised 12/11/2020)

Answer: Yes, both codes may be assigned, as aspiration pneumonia and pneumonia due to COVID-19 are two separate unrelated conditions with different underlying causes. This scenario meets the exception to the Excludes1 guideline as a circumstance when the two conditions are unrelated to each other.

Note that effective January 1, 2021, there is a new code, J12.82, for pneumonia due to coronavirus disease 2019.

Aspiration pneumonia and chronic obstructive pulmonary disease

Question: Does the advice published in *Coding Clinic*, Third Quarter 2016, pages 15-16, regarding chronic obstructive pulmonary disease (COPD) and pneumonia apply to all pneumonias, including aspiration pneumonia? Is the correct sequencing J44.0 and J69.0, in that order, or would the instructional note not apply to aspiration pneumonia and COPD?

Answer: Note from 3M: Please note that effective October 1, 2017, the "use additional code to identify the infection" note at code J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection, has been revised to "Code also to identify infection." See advice published in *Coding Clinic*, 4th Quarter 2017, page 96.

No, the instructional note at code J44.0, Chronic obstructive pulmonary disease, with acute lower respiratory infection, stating "Use additional code to identify the infection," does not apply to aspiration pneumonia. The ICD-10-CM code for aspiration pneumonia does not fall in the "respiratory infection" codes. Code J69.0, Pneumonitis due to inhalation of food and vomit, is under the section titled "Lung diseases due to external agents." Aspiration pneumonia is an inflammation of the lungs caused by the inhalation of solid and/or liquid matter.

Assign codes J44.9, Chronic obstructive pulmonary disease, unspecified, and J69.0, Pneumonitis due to inhalation of food and vomit, for a patient with chronic obstructive pulmonary disease and aspiration pneumonia. Sequencing of the two conditions will depend on the circumstances of admission.

AHA Coding Clinic, First Quarter 2021, pp. 34; First Quarter 2017, pp. 24

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Coding Clinic Review-Aspiration Pneumonia and Complication Coding



Respiratory and digestive system complications

Effective October 1, 2011, subcategory 997.3, Respiratory complications, has been expanded to create a new code, 997.32, Postprocedural aspiration pneumonia, to uniquely capture this condition and distinguish it from other respiratory complications. Code 997.32 includes chemical pneumonitis and Mendelson's syndrome when they result from a procedure.

Question: How should postoperative aspiration pneumonia be coded? Does it require one code or two?

Answer: Assign code 997.32, Postprocedural aspiration pneumonia. While there is a note at category 997 to "use additional code to identify complications," it is not necessary to also assign code 507.0, Pneumonitis due to solids and liquids, because code 507.0 does not provide greater specificity as to the nature of the condition. Code 997.32 already fully describes the complication. Refer to page 191 in this issue of Coding Clinic for additional information on the revised guideline for coding complications of care.

Aspiration pneumonia and lung transplant

Question: A patient with a history of bilateral lung transplant presents with aspiration pneumonia due to emesis with a continuous positive airway pressure (CPAP) mask. The *Official Guidelines for Coding and Reporting*, Section I.C.19.g.3, seem to suggest that any condition that would affect the function of the transplanted organ should be coded as a complication. What is the correct code assignment for aspiration pneumonia in a patient with a bilateral lung transplant?

Answer: Assign code T86.818, Other complications of lung transplant, followed by code J69.0, Pneumonitis due to inhalation of food and vomit, for the lung complication and aspiration pneumonia. The aspiration pneumonia has affected the function of the transplanted lung.

AHA Coding Clinic, Fourth Quarter 2011, pp. 148-150; Second Quarter 2019, pp. 6-7

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Summary

- The clinical indicators, treatments, and pathology of aspiration pneumonia must be understood by both clinicians and CDI specialists in order to correctly capture this important diagnosis in the medical record and final code set.
- Confirming aspiration pneumonia can impact your DRG and coding it correctly can impact important publicly reported quality metrics.
- Aspiration pneumonia is a topic that can be targeted by insurance companies for denial, so it is imperative to arm yourself with the knowledge and tools to defend this diagnosis when it is valid.
- It is crucial to become familiar with *Coding Clinic* advice on how to sequence and code Aspiration pneumonia in the context of sepsis, other respiratory diseases, and in post OP settings.

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Questions & Answers



**Natalie Negro, MPH, BSN,
RN, CCDS**
CDI Manager
Penn Medicine
Philadelphia, PA



Jisha Chacko, MSN, RN
CDI Specialist
Penn Medicine
Philadelphia, PA

To Submit a Question: Go to the Q&A box located in the lower left area of your screen. Type your question in the lower text box, then press your “Enter” key.

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<https://hcmarketplace.com/acdis-conference>

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HCPro, a division of Simplify Compliance LLC, 5511 Virginia Way, Suite 150, Brentwood, TN 37027
 Phone: 800-650-6787 Email: customerservice@hcpro.com Website: www.hcpro.com

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