

## 2019 IPPS FINAL RULE CAUTION

# Acute respiratory distress versus acute respiratory distress syndrome

One pivotal update included in the CMS fiscal year (FY) 2019 Inpatient Prospective Payment System (IPPS) Final Rule is the addition of acute respiratory distress syndrome (ARDS) to the list of diagnoses that count as major complicating conditions and comorbidities (MCC). Although this addition may be beneficial for those difficult cases with a paired DRG and very limited MCC opportunity, this update does not come without the likelihood of confusion or incorrect code assignment.

As documentation and guidelines are based on interpretation, the interpretation and documentation of “ARDS” may vary. The reader, whether they be a professional coder or a CDI specialist, must understand the clinical difference between *acute respiratory distress* as a symptom versus as a syndrome to establish complete and accurate code assignment. One codes to J80 (the syndrome) and the other codes to R06.03 (the symptom).

Respiratory distress and acute respiratory distress syndrome are not synonymous and cannot be used interchangeably. The physician must explicitly document the definitive diagnosis, clinical indicators, and treatment of the condition. Without explicit documentation, a clarification is warranted to omit coding error and to mitigate a denial.

According to a 2012 article in the *Journal of the American Medical Association (JAMA)*:

*ARDS is defined by timing (within 1 week of clinical insult or onset of respiratory symptoms); radiographic changes (bilateral opacities not fully explained by effusions, consolidation, or atelectasis); origin of edema (not fully explained by cardiac failure or fluid overload); and severity based on the PaO<sub>2</sub>/FiO<sub>2</sub> ratio on 5 cm of continuous positive airway pressure (CPAP). The 3 categories are mild (PaO<sub>2</sub>/FiO<sub>2</sub> 200-300), moderate (PaO<sub>2</sub>/FiO<sub>2</sub> 100-200), and severe (PaO<sub>2</sub>/FiO<sub>2</sub> ≤100).*

ARDS is the most severe form of acute lung injury, involving diffuse damage or injury to the alveoli and the lung capillary epithelium. Acute respiratory distress is simply a symptom, which is characterized by signs of abnormal respiratory status, difficulty breathing with increased or decreased rate or effort.

Although ARDS is a rare condition, CDI specialists may witness instances of ED documentation referring to the patient’s condition as “ARDS.” A one-time diagnosis or mention of “ARDS” in a patient’s medical record whose clinical presentation is respiratory distress is all it takes to result in a miscode and denial. Patients with ARDS have a prolonged length of stay, require more intensive and frequent monitoring/treatment, and have an increased risk of developing hospital-acquired infections. Therefore, the MCC update is ideal to reflect the accuracy of the patient’s condition

and severity of illness.

However, CDI staff need to remain vigilant to prevent misdiagnosis and miscoding of the condition. Without proper treatment and clinical indicators for a diagnosis of “ARDS,” CDI staff should clarify with a query. With a diagnosis of “respiratory distress,” but a rather prolonged length of stay, diagnostics, and intensive treatment, CDI staff need to clarify the information in the medical record.

**Editor’s note:** Angelica Naylor, MBA, BSN, RN, CCDS, the supervisor of the clinical documentation management program at North Kansas City Hospital in Missouri, wrote this article on behalf of the 2018 ACDIS CDI Regulatory Committee. For information about the committee and its work, contact Allen Frady ([afrady@acdis.org](mailto:afrady@acdis.org)).