Common Pulmonary Diseases Coding Quick Reference Guide

Risk Stratification refers to the alignment of patients with the right clinical initiatives, according to their clinical complexity. Accurately and completely documenting and communicating a patient's chronic diagnoses drives such care coordination and high-quality clinical care. Diagnosis coding and documentation should always capture the complete picture of a patient's health status at the highest level of specificity appropriate for the patient.

Clinical Information and Documentation Tips

Chronic pulmonary conditions should be assessed regularly. When diagnosing Asthma and COPD, PFTs are helpful.

Questions to Ask Before Choosing a Code:

Asthma:

- ✓ What is the severity? Mild, Moderate, Severe
- ✓ What is the frequency? Exercise/allergy induced, Intermittent, Persistent
- ✓ Is this an acute exacerbation? Is there an concomitant infection?
- ✓ Is it controlled or uncontrolled?

COPD:

- ✓ Are you able to determine if this is Emphysema or Chronic Bronchitis? If not, use COPD unspecified.
- ✓ What is the severity?
- ✓ Is this an acute exacerbation?
- ✓ Is the patient dependent on oxygen?

Reminders + Tips:

- When a patient with chronic lung disease is diagnosed with an acute exacerbation or an infection, make sure to also code for the chronic lung disease
- If a patient is immunosuppressed, be sure to address that and code for it as well.

Pulmonology Coding Quick Reference Guide

Best Documentation Practices

Subjective

In the subjective section of the office note, document the presence or absence of current symptoms related to the pulmonary disease. If there are no current symptoms, this section should show the patient was screened for symptoms.

Objective

The objective section should describe current physical exam findings related to the pulmonary disease and its complications or manifestations with cause-and-effect linkage clearly documented. Include results of related laboratory and other diagnostic testing.

When a patient has an exacerbation of their COPD, documentation needs to reflect the signs/symptoms of the exacerbation in the HPI, ROS or Exam:

- Cough
- Presence/absence of mucus
- Shortness of breath
- Wheezing
- Rhonchi or rales
- Decreased breath sounds

Assessment

Specificity: Document pulmonary diseases to the highest level of specificity. Include all of the following:

- **Type** – Centrilobular or panlobular emphysema, acute and/or chronic bronchitis, intermittent or persistent asthma, severity (mild/moderate/severe) etc.
- **Cause** – Document infectious agents (e.g., streptococcus pneumoniae), external agents (e.g., asbestos, chemicals, radiation), underlying diseases (e.g., autoimmune disease, neuromuscular disorders) or tobacco use/exposure. Use linking terms that clearly show cause-and-effect, such as "with," "due to," "secondary to," "associated with," "related to," etc.

Current status – With or without acute exacerbation, status asthmaticus, stable, etc.

Abbreviations: Limit, or avoid altogether, the use of abbreviations. Best practice is as follows: The initial notation of the condition should be spelled out in full with the abbreviation in parentheses: "chronic obstructive pulmonary disease (COPD)". Subsequent mention of COPD can be made using the abbreviation.

Current versus historical: Do not use the descriptor "history of" to describe current pulmonary diseases.

- In diagnosis coding, the phrase "history of" means the condition is historical and no longer exists as a current/active problem.

Suspected versus confirmed: Do not document a suspected condition as if it is confirmed. Instead, document the signs and symptoms in the absence of a confirmed diagnosis.

- Do not describe a confirmed pulmonary diagnosis with terms that imply uncertainty such as "probable," "apparently," "likely" or "consistent with".

Plan

- Document a specific and concise treatment plan
- Link medications to the diagnosis
- Include orders for radiology or other diagnostic tests
- If referrals are made or consultations requested, the office note should indicate to whom or where the referral of consultation is made or from whom consultation advice is requested.
- Include the date or time frame for the next appointment

Associated Conditions

Dependence on home oxygen (not associated with nocturnal hypoxemia) is a significant clinical indicator for chronic respiratory failure in patients with cardiopulmonary diseases.

Pulmonology Coding Quick Reference Guide

Common ICD-10 diagnosis codes

Chronic Obstructive Pulmonary Disease	ICD-10	V24 HCC	V28 HCC
Simple chronic bronchitis	J41.0	111	280
Mucopurulent chronic bronchitis	J41.1	111	280
Mixed simple and mucopurulent chronic bronchitis	J41.8	111	280
Unspecified chronic bronchitis	J42	111	280
Panlobular emphysema	J43.1	111	280
Centrilobular emphysema	J43.2	111	280
Emphysema, unspecified	J43.9	111	280
Chronic obstructive pulmonary disease w/ (acute) lower respiratory infection	J44.0	111	280
Chronic obstructive pulmonary disease with (acute) exacerbation	J44.1	111	280
Chronic obstructive pulmonary disease, unspecified	J44.9	111	280

Asthma (further define as uncomplicated/acute exacerbation/status asthmaticus)	ICD-10	V24 HCC	V28 HCC
Mild intermittent asthma	J45.2*	_	_
Mild persistent asthma	J45.3*	_	_
Moderate persistent asthma	J45.4*	_	_
Severe persistent asthma	J45.5*	_	279
Unspecified asthma	J45.90*	_	_

Note: Commercial payers (Health & Human Services, HHS) consider asthma an HCC, but (Centers for Medicare & Medicaid Services, CMS) does not.

*Indicates additional character(s) required to complete code assignment

Pulmonology Coding Quick Reference Guide

Common ICD-10 diagnosis codes

Other Lung Disorders	ICD-10	V24 HCC	V28 HCC
Sarcoidosis of lung	D86.0	112	_
Cystic Fibrosis with pulmonary manifestations	E84.0	110	277
Lobar pneumonia, unspecified organism	J18.1	115	_
Pneumonia, unspecified organism	J18.9	_	_
Bronchiectasis, uncomplicated	J47.9	112	280
Chronic respiratory conditions due to chemicals , gases, fumes and vapors	J68.4	112	280
Aspiration pneumonia NOS	J69.0	114	282
Chronic and other pulmonary manifestations due to radiation	J70.0	112	_
Pulmonary fibrosis, unspecified	J84.10	112	280
Idiopathic pulmonary fibrosis	J84.112	112	278
Lung involvement in systemic lupus erythematosus	M32.13	40/112	280/94
Sjogren syndrome with lung involvement	M35.02	40/112	_

Additional Codes	ICD-10	V24 HCC	V28 HCC
Nicotine dependence*	F17.*	_	_
Chronic respiratory failure with hypoxia	J96.11	84	213
Tobacco use	Z72.0	_	_
History of tobacco dependence	Z89.891	_	_
Tracheostomy status	Z93.0	82	211
Dependence on supplemental oxygen	Z99.81	_	_

*Indicates additional character(s) required to complete code assignment