Part B Insider (Multispecialty) Coding Alert

Pulmonology Coding: 493.2x Doesn't Have to Confuse You--If You Have the Right Documentation

When does status asthmaticus supercede COPD? Find out.

Your physician's notes may be your best bet when a patient presents to the doctor with asthma or bronchitis, and symptoms of chronic obstructive pulmonary disease (COPD).

Having the right information ready before referring to your ICD-9 manual could also save you from trouble. How do you do that? First, make sure the documentation supports the physician's diagnosis. Then, be on the lookout for any associated acute conditions.

When faced with the situation, asking these 3 vital questions can help you breathe easily through your lung diagnosis coding.

1. Do You See Any Sign of COPD-Associated Asthma?

If a physician diagnosed a patient with both asthma and COPD, you should go to the 493.x section of ICD-9 and choose from the three options:

493.20 -- Chronic obstructive asthma; unspecified

493.21 -- Chronic obstructive asthma; with status asthmaticus

493.22 -- Chronic obstructive asthma; with (acute) exacerbation.

Some payers regard 493.20 as default codes. It's always safe to check with your physician irst to see if the patient has status asthmaticus or acute exacerbation before settling with 493.20.

Careful: A diagnosis of "status asthmaticus" is the most acute presentation and takes precedence over any type of COPD, so you should primarily list the most acute diagnosis addressed if the physician documents both findings. On the claim, you should report 493.21, not 493.22 (an acute exacerbation). "If status asthmaticus is documented by the provider with any type of COPD or with acute bronchitis, the status asthmaticus should be sequenced first," according to chapter 8, section 1C of the ICD-9-CM Guidelines. "It supersedes any type of COPD including that with acute exacerbation or acute bronchitis."

2. Does the MD Diagnose COPD Along with Bronchitis?

When your doctor documents chronic obstructive bronchitis with an episode of acute bronchitis, you should report 491.22 (Obstructive chronic bronchitis; with acute bronchitis).

Reporting 466.0 (Acute bronchitis) for the obstructive chronic bronchitis is inaccurate because 466.0 fails to capture the patient complexity of an acute-on-chronic illness, as in 491.22.

More scenarios: Your physician documents that a patient has acute bronchitis with chronic obstructive bronchitis, and that it is causing an acute exacerbation. What should you report?

Bill 491.22 just the same since ICD-9 guidelines state that the bronchitis supersedes the exacerbation for coding purposes. In other words, the physician can definitively identify the patient's acute problem, that of acute bronchitis in a patient who also has chronic bronchitis.

On the other hand, if the documentation states that the patient has chronic obstructive bronchitis with acute exacerbation but doesn't mention acute bronchitis, you should report 491.21 (Obstructive chronic bronchitis; with [acute] exacerbation).

If the physician mentions stable COPD with no other associated manifestations or conditions such as chronic bronchitis or emphysema, you should go for 496 (Chronic airway obstruction, not elsewhere classified).

3. Did You Get Complete Documentation From the Doctor?

Full details play especially important if you're coding COPD. Make sure the documentation includes a listing of signs, symptoms, and conditions.

A simple entry of "shortness of breath and cough" may not suffice. Many cardiopulmonary diseases manifest themselves in this fashion, so these symptoms can represent a progression of chronic illness or other acute issues, either related or unrelated to the patient's chronic disease. Therefore, clinical evaluation, based on a detailed history, is of prime importance. To determine a new illness or a progressing/exacerbating chronic illness, the physician may order blood studies, along with radiographical and physiological evaluations.

Listing merely COPD as the diagnosis does not reflect the patient's current status. Including the signs, symptoms, or the exacerbation will assist in justifying the medical necessity of the studies ordered. The payer will better understand that these are not routine surveillance studies.

How to do it: Take a full system review, consider past medical history, and identify risk factors involving the family history and social history. These are important steps when your physician performs an E/M service on a patient with COPD.

A comprehensive exam assists the physician in determining the systemic effects of COPD. After determining the plan of care, be sure to document any necessary testing, such as x-rays (71010-71035) and pulmonary function tests (PFT, such as 94010-94060), along with the management option selected.