Part B Insider (Multispecialty) Coding Alert

Reader Question: Documentation Should Support Diagnoses

Question: Our physician circled an initial diagnosis of COPD (chronic obstructive pulmonary disease) but during an audit I could not determine whether his documentation actually supported the diagnosis. Can you tell me what to look for in the documentation that would support a COPD assignment?

Answer: Physicians will base an initial COPD diagnosis on several factors, and the best documentation will include extensive information about each factor. Most COPD documentation will include:

- In the **HISTORY**: Should include whether or not the patient had a history of cigarette smoking. The vast majority of COPD patients have a history of smoking cigarettes. The remaining patients have a history of exposure to pollutants, dusts and chemicals, evidence of genetic tendency (such as alpha-1 Antitrypsin) or history of chronically and poorly controlled asthma.
- In the **SYMPTOMS:** Shortness of breath (also known as dyspnea) and cough are the cardinal symptoms. Excessive sputum production, wheezing, and recurrent upper respiratory tract infections (URI) are commonly present.
- In the **RADIOGRAPHICAL** workup: The chest x-ray shows hyperinflation with flattening of the diaphragms. The CT of the chest is more sensitive and can correlate more accurately with the severity of COPD, so include details about these tests results.
- In the **PHYSIOLOGICAL** workup: Pulmonary function testing (PFT) is the confirmatory test. You cannot make a solid diagnosis of COPD without having PFT in the medical record. Flow-rate limitation on spirometry and air trapping on the lung volumes are the hallmark findings. Reduced diffusion lung capacity for carbon monoxide (DLCO) is in favor of emphysema, while normal DLCO is in favor of chronic bronchitis.
- In the **BLOOD WORK,** there are no specific findings until the advanced stage of the disease. Arterial blood gases (ABG) will show evidence of respiratory failure: In emphysema, hypoxemia is more pronounced, while in chronic bronchitis, hypercapnea (CO_2 retention) is more evident. Chronic hypoxemia can result in erythrocytosis (elevated hemoglobin and hematocrit) on the complete blood count (CBC), while CO_2 retention will lead to elevation of serum bicarbonate (HCO_3^-) on the electrolytes. Your physician should include all of these readings in his documentation when he first diagnoses the patient with COPD.