NeueHealth™

Coding and Documentation Guide: COPD and Asthma

Accurate coding and documentation are fundamental to the risk adjustment process and crucial to representing each patient's complex health profile. Bright HealthCare's coding and documentation guides equip coders and medical staff with the information needed to support complete and accurate coding and documentation.

Documentation best practices

- Documentation must be provided. Coders cannot assume diagnoses exist based on medication lists or physician orders.
- All conditions that coexist at the time of the encounter, and require or affect patient care, treatment, or management should be documented and coded.
- Coders cannot code current conditions from problem lists, medical history, or superbills.
- Coders must verify clinical documentation for all diagnoses using the MEAT tool (monitor, evaluate, assess, treat). One or more MEAT detail is required for each condition requiring or affecting patient care.

Monitor	**Evaluate**	**Assess**	**Treat**
Symptoms Disease progression/ regression Ordering of tests Referencing labs/tests	Test results Medication effectiveness Response to treatment Physical exam findings	Test ordered Counseling Record review Discussion	Medication Therapies Referral Other modalities
MEAT Examples: COPD & asthma			
Exacerbation of moderate persistent asthma — Patient is improving; we will continue monitoring.	Asthma with COPD — Patient relief from rapid-acting bronchodilator treatment.	COPD with chronic bronchitis — Discussed smoking cessation and reviewed breathing exercises.	Severe persistent asthma, uncomplicated — Continue current inhaler therapy and follow up with Dr. X for further management.

Coding and documentation examples

Case study #1: Complete documentation

Gender: F **DOB:** MM/DD/1970

History of present illness

Pt is here today to establish care and for evaluation of asthma symptoms.

Patient has asthma symptoms and reactive airway disease present over the past 3 years, with symptoms increasing recently. This is perhaps from allergies, perhaps from GI issues/silent reflux. She used her albuterol inhaler 3 or 4 times yesterday. She started Singulair yesterday and since that time has not had any shortness of breath or cough. No fever or chills. Patient is a non-smoker.

Medications

- Albuterol 90 mcg/actuation inhaler; inhale 1-2 puffs by mouth every 6 hours as needed for wheezing.
- Loratadine (CLARITIN) 10 mg tablet; take 10 mg by mouth daily.
- Montelukast (SINGULAIR) 10 mg tablet; take one by mouth nightly.

PFSH

- Asthma
- Seasonal allergies

Exam

CONSITUTIONAL
Appearance: She is well-developed.

HENT
Head: Normocephalic and atraumatic.

NECK
Musculoskeletal: Normal range of motion and neck supple.
Thyroid: No thyromegaly.

CARDIOVASCULAR
Rate and rhythm: Normal rate and regular rhythm.

PULMONARY
Effort: Pulmonary effort is normal. No respiratory distress.
Breath sounds: No stridor. Wheezing (with forced expiration) present. No rhonci or rales.

NEUROLOGICAL
Mental status: She is alert.
Coordination: Coordination normal.

PSYCHIATRIC
Behavior: Behavior normal.
Judgment: Judgment normal.

Assessment & plan

Moderate persistent asthma without complication – Discussion with patient about using a peak flow meter. Continue Singulair and albuterol. Perhaps exacerbated by recent GI issues; she has follow-up with GI tomorrow. Follow-up here if not improving. We did discuss possible referral to allergy and asthma specialist and complete pulmonary function testing.

Jane Doe, MD

Documentation supports moderate persistent asthma without complication (J45.40).

Reason for visit is clearly documented.

Documentation includes MEAT details: current symptoms and medication effectiveness.

Assessment and plan clearly states patient has moderate persistent asthma without complication, and provider is treating patient for this.

Case study #2: Missed opportunity

Gender: F **DOB:** MM/DD/1957

History of present illness
Pt is a pleasant 63-year-old female who presents today to discuss the following complaints:

1. OSA (obstructive sleep apnea) – Poorly controlled, will need to get sleep study done.
2. Anxiety – Stable, no acute complaints, fully adherent to medication, denies any adverse effects.
3. Exertional shortness of breath – Pt with SOB at baseline which is more pronounced than is typical when she exerts herself.
4. Precordial pain – Pt with intermittent precordial pain, asymptomatic presently.

PMH
COPD (chronic obstructive pulmonary disease)

Meds

- Albuterol 2/5 mg/3 mL (0.083%) nebulizer solution; inhale 3 mL (2.5 mg) by nebulization every 6 hours as needed for wheezing.
- Tiotropium-olodaterol (Stiolto Respimat) 2.5-2.5 mcg/actuation mist; inhale 2 inhalations by mouth daily.
- Buspirone (BuSpar) 30 MG tablet; take 1 tablet (30 mg) by mouth 2 times a day.

Past medical history states COPD.

Patient is on medications that are commonly used to treat COPD: Albuterol, tiotropium.

Assessment & plan
Anxiety: Stable, no acute complaints. Fully adherent to medication. Denies any adverse effects. Continue current treatment.

OSA (obstructive sleep apnea): Poorly controlled. Ambulatory referral to Sleep Medicine for sleep study.

Exertional shortness of breath: Pt with SOB at baseline which is more pronounced than is typical when she exerts herself, will order ECHO to r/o HF.

Precordial pain: Pt with intermittent precordial pain, asymptomatic presently, discussed options, pt agrees to contact cardiologist and in the meantime we will get an ECHO.

John Doe, MD

The assessment and plan do not mention COPD or treatment for COPD.

Without confirmation from the provider that COPD is an active condition, we cannot code for COPD.

Coding COPD and asthma

Diagnosis	Code
Simple chronic bronchitis**	J41.0
Mucopurulent chronic bronchitis**	J41.1
Mixed simple and mucopurulent chronic bronchitis**	J41.8
Unspecified chronic bronchitis**	J42
Unilateral pulmonary emphysema [MacLeod's syndrome]**	J43.0
Panlobular emphysema**	J43.1
Centrilobular emphysema**	J43.2
Other emphysema**	J43.8
Emphysema, unspecified**	J43.9
Chronic obstructive pulmonary disease with (acute) lower respiratory infection**	J44.0
Chronic obstructive pulmonary disease with (acute) exacerbation**	J44.1
Chronic obstructive pulmonary disease, unspecified**	J44.9
Mild intermittent asthma, uncomplicated*	J45.20
Mild intermittent asthma with (acute) exacerbation*	J45.21
Mild intermittent asthma with status asthmaticus*	J45.22
Mild persistent asthma, uncomplicated*	J45.30
Mild persistent asthma with (acute) exacerbation*	J45.31
Mild persistent asthma with (acute) exacerbation*	J45.32
Moderate persistent asthma, uncomplicated*	J45.40
Moderate persistent asthma with (acute) exacerbation*	J45.41
Moderate persistent asthma with status asthmaticus*	J45.42
Severe persistent asthma, uncomplicated*	J45.50
Severe persistent asthma with (acute) exacerbation*	J45.51
Severe persistent asthma with status asthmaticus*	J45.52
Unspecified asthma with (acute) exacerbation*	J45.901
Unspecified asthma with status asthmaticus*	J45.902
Unspecified asthma, uncomplicated*	J45.909
Exercise induced bronchospasm*	J45.990
Cough variant asthma*	J45.991
Other asthma*	J45.998
Bronchiectasis with acute lower respiratory infection**	J47.0
Bronchiectasis with (acute) exacerbation**	J47.1
Bronchiectasis, uncomplicated**	J47.9
Interstitial emphysema**	J98.2
Compensatory emphysema**	J98.3

*Risk adjusts in HHS-HCC model only.

**Risk adjusts in CMS-HCC model and HHS-HCC model.

Clinical indicators

Familiarity with COPD and asthma clinical indicators (i.e., testing, treatment, medication, etc.) is helpful in recognizing the potential presence and severity of a condition. **Coders cannot assign diagnosis codes based solely on test results and medication lists**, but these clinical indicators can help highlight opportunities for more complete and accurate documentation.

Common tests used to diagnose COPD and asthma

Test	Purpose
Allergy testing	Allergy tests can be performed with a skin test or blood test. Allergy tests identify pet, dust, mold, and pollen allergies.
Arterial blood gas analysis	This blood test measures how well the lungs are bringing oxygen into the blood and removing carbon dioxide.
Chest x-ray	A chest x-ray can show emphysema, one of the leading causes of COPD. An x-ray can also rule out other lung problems or heart failure.
CT scan	A CT scan of the lungs can help detect emphysema and help determine if surgery for COPD would be beneficial. CT scans can also be used to screen for lung cancer.
Laboratory tests	Lab tests aren't used to diagnose COPD, but they can determine the cause of symptoms or rule out other conditions. For example, lab tests can determine if a person has the genetic disorder alpha-1-antitrypsin deficiency, which can cause COPD in some people.
Lung function tests (e.g., spirometry, peak flow, pulse oximetry)	These tests measure the amount of air a person can inhale and exhale and whether the lungs deliver enough oxygen to the blood.
Methacholine challenge	Methacholine is a known asthma trigger. When inhaled, it will cause the airways to narrow slightly. If a patient reacts to methacholine, they likely have asthma. This test may be used even if a patient's initial lung function test is normal.
Nitric oxide test	This test measures the amount of gas nitric oxide in a person's breath. When a patient's airways are inflamed (a sign of asthma) they may have higher than normal nitric oxide levels.
Provocative testing for exercise and cold-induced asthma	In these tests, the provider measures a patient's airway obstruction before and after vigorous physical activity or several breaths of cold air.

How asthma is classified

Asthma classification	Signs and symptoms
Mild intermittent	Mild symptoms up to two days per week and up to two nights per month
Mild persistent	Symptoms more than twice per week, but no more than once in a single day
Moderate persistent	Symptoms once per day and more than one night per week
Severe persistent	Symptoms throughout the day on most days and frequently at night

Common medications used to treat COPD and asthma

Brand name	Generic	Classification
ProAir HFA, Ventolin HFA	Albuterol	Short-acting bronchodilator
Atrovent HFA	Ipratropium	Short-acting bronchodilator
Xopenex	Levalbuterol	Short-acting bronchodilator
Tudorza Pressair	Aclidinium	Long-acting bronchodilator
Brovana	Arformoterol	Long-acting bronchodilator
Perforomist	Formoterol	Long-acting bronchodilator
Arcapta Neohaler	Indacaterol	Long-acting bronchodilator
Spiriva	Tiotropium	Long-acting bronchodilator
Serevent	Salmeterol	Long-acting bronchodilator
Incruse Ellipta	Umeclidinium	Long-acting bronchodilator
Flovent HFA	Fluticasone	Inhaled steroids
Pulmicort Flexhaler	Budesonide	Inhaled steroids
Singulair	Montelukast	Leukotriene modifiers
Accolate	Zafirlukast	Leukotriene modifiers
Zyflo	Zileuton	Leukotriene modifiers
Breo Ellipta	Fluticasone and vilanterol	Combination inhaler
Trelegy Ellipta	Fluticasone umeclidinium and vilanterol	Combination inhaler
Symbicort	Formoterol and budesonide	Combination inhaler
Advair HFA, AirDuo Digihaler	Salmeterol and fluticasone	Combination inhaler
Daliresp	Roflumilast	Phosphodiesterase-4 inhibitor
Elixophyllin, Theo-24, Theochron	Theophylline	Theophylline
Zithromax	Azithromycin	Antibiotics