

Focus on Chronic Obstructive Pulmonary Disease (COPD)



Quick Facts

- Chronic obstructive pulmonary disease (COPD) is a preventable and treatable disease and is the only disease among the top 10 causes of death that is increasing in frequency.^{1,2,3}
- It is anticipated that the prevalence of COPD will continue to increase through the year 2020 and beyond.³
- Early identification of COPD can help to reduce the morbidity and mortality that is associated with COPD in at-risk populations.¹
- Cigarette smoking is the most significant determinant of the development and progression of COPD.¹
- As a slowly progressive disease, the clinical diagnosis of COPD is often not made until extensive and irreparable damage has occurred.¹ In most cases, patients seeking medical attention for COPD have acute exacerbations and present with later stage disease at first diagnosis.^{1,2}
- COPD remains undiagnosed by a physician in as many as 30 million individuals.³
- Most patients presenting to their healthcare provider for symptoms related to COPD have an FEV1 that is < 50% predicted.³
- The National Health and Nutrition Examination Survey revealed that 25% of white male smokers had evidence of airway obstruction, as documented by an FEV1/FVC ratio of < 70%.³

Documentation Tips^{5,6}

COPD (**496**) is a nonspecific code that should only be used when documentation does not specify the type and should not be used with code categories 491-493.

Obstructive chronic bronchitis (**491.2x**) necessitates a 5th digit requiring specific documentation to indicate with or without acute exacerbation, or with acute bronchitis:

- Documentation must support a worsening or decompensation of the COPD condition itself to validate as an acute exacerbation.

Chronic obstructive asthma (**493.2x**) necessitates a 5th digit requiring

specific documentation to indicate with or without the presence of status asthmaticus or acute exacerbation.

Coding Highlights⁷

- Tobacco Use Disorder (305.1)
- Smokers' Cough (**491.0**)
- Hypoxemia (**799.02**)
- History of Tobacco Use (V15.82)
- Tracheostomy Status (**V44.0**)
- Dependence on respirator/ventilator, status (**V46.11**)
- Supplemental oxygen (V46.2)
Long-term oxygen therapy
- Attention to Tracheostomy (**V55.0**)

Coding COPD

491.0	Simple Chronic Bronchitis	491.9	Chronic Bronchitis, Unspecified
491.1	Mucopurulent Chronic Bronchitis	492.8	Emphysema, NOS
491.20	Obstructive Chronic Bronchitis w/o Exacerbation	493.20	Chronic Obstructive Asthma, Unspecified
491.21	Obstructive Chronic Bronchitis w/ (Acute) Exacerbation	493.21	Chronic Obstructive Asthma w/ Status Asthmaticus
491.22	Obstructive Chronic Bronchitis w/ Acute Bronchitis	493.22	Chronic Obstructive Asthma w/ (Acute) Exacerbation
491.8	Chronic Bronchitis, Other	496	Chronic Airway Obstruction (COPD), NEC

Who Should Be Screened²

Spirometry should be obtained in all persons with the following history:

- Exposure to cigarettes and/or environmental or occupational pollutants.
- Family history of chronic respiratory illness.
- Presence of cough, sputum production or dyspnea.

Diagnosis of COPD²

- Chronic obstructive pulmonary disease (COPD) is characterized by airflow limitation that is not fully reversible.
- The diagnosis is confirmed with spirometry. Post-bronchodilator FEV1/forced vital capacity <0.7 confirms the presence of airflow limitation that is not fully reversible.

- Assessment of COPD severity is performed using spirometry, dyspnea and body mass index (BMI).

The following factors favor the diagnosis of COPD and may help clinicians distinguish between asthma and COPD:

- A history of smoking of at least 10 pack-years
- Evidence of emphysema on imaging
- Decreased diffusing capacity
- Chronic hypoxemia

Key Risk Factors

Diagnosis of COPD should be considered in any patient who has the following:^{2,4}

- Symptoms of cough
- Sputum production or
- Dyspnea or
- History of exposure to risk factors for the disease such as cigarette smoking

¹ Stang, P., The Prevalence of COPD*: *Using Smoking Rates to Estimate Disease Frequency in the General Population*. Chest 2000;117;354S-359S.

² American Thoracic Society/European Respiratory Society Task Force. Standards for the Diagnosis and Management of Patients with COPD [Internet]. Version 1.2. New York: American Thoracic Society; 2004 [updated 2005 September 8]. Available from: <http://www.thoracic.org/go/copd>.

³ Blecker, Eugene R. Similarities and Differences in Asthma and COPD*10.1378/chest.126.2_suppl_1.93S CHEST August 2004 vol. 126 no. 2 suppl 1 93S-95S.

⁴ Rabe KF, et al. Global strategy for the diagnosis, management and prevention of chronic obstructive pulmonary disease: *GOLD executive summary*. Am J Respir Crit Care Med. 2007 Sep 15;176(6):532-55. Epub 2007 May 16.

⁵ *AHA Coding Clinic (1984). Chronic obstructive pulmonary disease (COPD) guidelines*. 2nd Quarter.

⁶ 2012 Coders' Desk Reference for Diagnosis. Alexandria, VA: Ingenix, 2011. p. 447-448.

⁷ *AHA Coding Clinic (2005). Asphyxia and hypoxemia*. 4th Quarter.