

Zack Gerbarg, MD, CPC (certified professional coder), editor

## Common Pulmonary Diseases: Documentation and Coding

**Example:** Progress note: COPD with chronic respiratory failure  
Diagnosis code: 496, 518.83

The Centers for Medicare and Medicaid (CMS) are requiring physicians to accurately document and code pulmonary diseases in order to evaluate patient severity.

Even for patients with long-standing chronic pulmonary disease (chronic bronchitis, emphysema, or COPD), it is important at least once each calendar year for physicians to document in their medical records and submit in their claims the correct ICD-9 diagnosis codes. Common pulmonary diseases that impact Medicare severity adjustment include:

ICD-9 code    Documentation

**481**            pneumococcal pneumonia

**491.20**        obstructive chronic bronchitis, without exacerbation

**491.21**        obstructive chronic bronchitis, with acute exacerbation

**491.9**            chronic bronchitis

**492.8**            emphysema

**493.20**        chronic obstructive asthma, unspecified

**496**            COPD

**V44.0**          tracheostomy

**518.83**        chronic respiratory failure

**162.9**        primary lung cancer

(note: **198.3** metastatic to brain; **198.5** metastatic to bone; **196.9** metastatic to lymph node)

**197.0**        secondary lung cancer (metastatic to lung from other source)

**Example:** The correct documentation and coding for a patient with pulmonary disease seen at least once each year might be:

- **Progress note:** patient with emphysema, tracheostomy functioning well
- **Diagnosis codes:** 492.8, V44.0
  
- **Progress note:** lung cancer with metastases to brain, undergoing treatment
- **Diagnosis codes:** 162.9, 198.3

**Basic principles of diagnosis coding:**

Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record which is dated and signed by a physician. **A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.**

The information and examples provided above are minimal documentation to support diagnosis coding as only one part of a complete progress note. Final decisions about diagnosis coding should be based on review of standard reference materials.