Medicare Advantage Chronic Obstructive Pulmonary Disease (COPD)

Documentation and coding in the ICD-10-Clinical Modification (CM)
Our Mission & Guiding Principles

Cigna Mission Statement
To improve the health, well-being, and peace of mind of those we serve.

Our Guiding Principles

• Listen & learn from our customers.
• Do the right thing. Always.
• Be courageous and decisive.

Today’s presentation was designed to support clinicians in developing an accurate coding and documentation skill set. Precise coding and documentation supports high quality patient care delivery, with the hope of reducing administrative burdens to your practice and your Cigna patients.
Government Enforcement Risks

• In recent years, the U.S. Department of Justice and the Department of Health & Human Services have focused increasingly on investigations of alleged fraud, waste, and abuse in the Medicare Advantage program

• These investigations often evaluate the accuracy of diagnoses submitted by providers, among other compliance concerns

• Providers must be diligent about confirming the accuracy of their diagnoses and ensure that their diagnosis and coding practices comply with all applicable legal requirements

• Failure to address recurrent diagnosis inaccuracies can, in some cases, result in administrative sanctions and potential financial penalties
Chronic Care Quality Initiative (CCQI)

CCQI focuses on improving customer health outcomes by supporting clinicians and the local markets with the “360/Arcadia 360” initiative.

CCQI programming includes:

• Providing information related to previous chronic condition
• Assist providers to ensure previous chronic conditions are accurately identified
• Documentation and general coding educational materials, lectures and individual coaching
• Auditing 360s and providing feedback to clinicians, market operations and vendors
• Supporting vendor relationships
• Bridging the gaps between the local markets and the enterprise
Accreditation & Disclosure

Accreditation:
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Illinois Academy of Family Physicians and Cigna. The Illinois Academy of Family Physician’s is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation:

AMA PRA Category 1-The Illinois Academy of Family Physicians designates this web based enduring material, “COPD: Coding and Documentation,” for a maximum of 0.25 AMA PRA Category 1 credit™.

Faculty Disclosure Statement:

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Speaker & Faculty Disclosures:

Michael Fessenden, MD, Nancy Gray, APRN-C, FNP-C, Donna “Michele” Prichard, RN, ANP-BC, MS, Linda Small RHIA, CDIP, CCS and Sara Ortega (IAFP Staff) disclosed no relevant financial relationship or interest with a proprietary entity producing, marketing, reselling or distributing health care goods or services.

This program does not include any discussion or demonstration of any pharmaceuticals or medical devices that are not approved by the Food and Drug Administration (FDA) or that are considered “off-label.”
COPD

OBJECTIVES

Describe
Clinical definition of COPD

Utilize
Key documentation elements to promote accurate and specific coding of COPD

Describe
Centers for Medicare & Medicaid Services (CMS) related services, guidance for documentation, and coding
General documentation guidelines

Explicitly document findings to support diagnosis of COPD

Document a diagnostic statement that is compatible with ICD-10-CM nomenclature

Explicitly document treatment plan and follow-up

Confirm face-to-face encounter is signed and dated by clinician. Include printed version of clinician’s full name and credentials (e.g., MD, DO, NP, PA)
Not only should you document what is present,

Do not document or support a diagnosis that you believe does NOT exist

If you believe any codes were previously submitted in error (for example, the patient never had the condition listed), contact your provider education specialist or CCQI@healthspring.com & provide the patient name and diagnosis code so the code can be researched and retracted, if appropriate.

Fraud, Waste, and Abuse
To report suspected or detected Medicare program non-compliance please contact Cigna Medicare Advantage Compliance Department at:
Cigna Medicare Advantage
Attn: Compliance Department
PO Box 20002
Nashville, TN 37202
1-800-230-6138
Monday through Friday, 8 a.m. to 6 p.m. CST
Chronic Obstructive Pulmonary Disease (COPD) is a common, preventable and treatable disease that is characterized by persistent respiratory symptoms and airflow limitation that is due to airway an/or alveolar abnormalities usually caused by significant exposure to noxious particles or gases and influenced by host factors including abnormal lung development. Significant comorbidities may have an impact on morbidity and mortality.1

### Chronic bronchitis

- Chronic bronchitis is defined as a chronic productive cough for three months in each of two successive years in a patient in whom other causes of chronic cough (e.g., bronchiectasis) have been excluded. It may precede or follow development of airflow limitation (Global Initiative for Chronic Obstructive Lung Disease-2020)1

### Emphysema

- Emphysema is a pathological term that describes some of the structural changes sometimes associated with COPD. These changes include abnormal and permanent enlargement of the airspaces distal to the terminal bronchioles that is accompanied by destruction of the airspace walls, without obvious fibrosis (i.e., there is no fibrosis visible to the naked eye)2

### Asthma

- Asthma is a common, chronic respiratory disease, usually characterized by chronic airway inflammation. It is defined by the history of respiratory symptoms such as wheeze, shortness of breath, chest tightness and cough that vary over time and in intensity, together with variable expiratory airflow limitation3 (Global Initiative for Asthma-2019)3

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COPD Prevalence

- During 2014-2015, 5.9% of adults (more than 15.9 million) reported having been diagnosed with COPD and approximately 15.1% of U.S. adults reported being smokers.  

- In 2017, the CDC Chronic disease Indicators listed mortality with COPD as underlying cause among adults aged > 45 years was 113.4/100,000 cases (age-adjusted rate). 

- The prevalence of COPD varies considerably by state, from <4% in Hawaii, Colorado, and Utah to >9% in Alabama, Tennessee, Kentucky, and West Virginia. States with the highest COPD prevalence are clustered along the Ohio and lower Mississippi Rivers. 

- Number of adults with diagnosed chronic bronchitis in 2018, U.S. was 9.0 million.

- In 2016, number of physician office visits with emphysema and other chronic obstructive pulmonary disease as the primary diagnosis: 5.7 million.

- In 2017 COPD was ranked 4th for cause of death in the U.S.

- In 2017, the number of emergency department visits with emphysema and other chronic obstructive pulmonary disease as the primary diagnosis was 923,000.
COPD
Risk factors

1. Smoking
2. Indoor/Outdoor air pollution
3. Family history of COPD
4. Occupational dusts, chemicals, fumes, and gases
5. Frequent lower respiratory infections during childhood
6. Genetic factors

Spirometry

COPD Diagnosis

COPD should be considered in any patient who has dyspnea, chronic cough or sputum production, and/or history of exposure of risk factors for the disease.

> Necessary to make diagnosis of COPD
> The presence of a post-bronchodilator FEV1/FVC < 0.70 confirms the presence of persistent airflow limitation and thus of COPD in patients with appropriate symptoms and significant exposures to noxious stimuli.
> GOLD and NICE are two classifications systems available to categorize disease severity based on spirometry results. And symptom assessment using a validated questionnaire.

COPD Evaluation

**Differential Diagnosis**
- Chronic obstructive asthma
- Chronic bronchitis with normal spirometry
- Central airway obstruction
- Bronchiectasis
- Heart failure
- Tuberculosis
- Constrictive bronchiolitis
- Lung cancer
- Diffuse panbronchiolitis
- Tracheal stenosis

**Laboratory**
- Anemia
- BNP
- Blood glucose
- Urea nitrogen
- Creatinine
- Electrolytes
- Calcium
- Phosphorus
- TSH
- Sodium bicarbonate
- Alpha-1 antitrypsin (AAT) deficiency
- Arterial blood gases

**Imaging**
- Chest radiography
- Computed tomography
Physical Exam

**Early:**
- May be normal
- Prolonged expiration or wheezes on forced exhalation
- Hyperinflation, decreased breath sounds, wheezes, crackles at lung bases, and/or distant heart sounds.

**Severe:**
- ↑ A/P diameter (barrel chest)
- Depressed diaphragm with limited movement on chest percussion

**End Stage:**
- Posture changes
- Callouses or swollen bursae on forearms
- Use of accessory respiratory muscles (neck shoulder girdle)
-Expiration through pursed lips
- Cyanosis
- Paradoxical retraction of lower intercostal spaces with inspiration
- Enlarged, tender liver
- Neck vein distention

**Other symptoms:**
- Yellow stains on finger
- Clubbing of digits (not typical)
COPD Treatment\textsuperscript{14,15,16}

- Smoking Cessation
- Pharmacotherapy
- Pulmonary rehab
- Long-term oxygen therapy
- Vaccinations
- Surgery
- Referral


\textsuperscript{15} Gentry, S. & Gentry, B. Chronic Obstructive Pulmonary Disease: Diagnosis and Management. American Family Physician. 2017;95(7):433-441.

ICD-10 Clinical Modification
## COPD

### ICD-10-CM codes

<table>
<thead>
<tr>
<th>ICD-10-CM code</th>
<th>ICD-10-CM description</th>
<th>Definition and tip</th>
</tr>
</thead>
</table>
| J44            | Other chronic obstructive pulmonary disease, unspecified | Includes:  
  - Asthma with COPD  
  - Chronic (asthmatic) obstructive bronchitis  
  - Chronic bronchitis with airways obstruction  
  - Chronic bronchitis with emphysema  
  - Chronic emphysematous bronchitis  
  - Chronic obstructive asthma  
  - Chronic obstructive bronchitis  
  - Chronic obstructive tracheobronchitis |

Code also type of asthma, if applicable (J45.-)  
Use additional code to identify:  
- Tobacco dependence (F17.-)  
- Tobacco use (Z27.0)  
- History of tobacco dependence (Z87.891)  
- Exposure to environmental tobacco smoke (Z77.22)  
- Occupational exposure to environmental tobacco smoke (Z57.31)
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<tbody>
<tr>
<td>J44.0</td>
<td>Chronic obstructive pulmonary disease with (acute) lower respiratory infection</td>
<td>Code also to identify the infection Do not assign when only aspiration pneumonia is present</td>
</tr>
</tbody>
</table>
| J44.1          | Chronic obstructive pulmonary disease with (acute) exacerbation | Decompensated COPD Decompensated COPD with (acute) exacerbation Excludes:  
• Chronic obstructive Pulmonary disease (COPD) with acute bronchitis (J44.0)  
• Lung diseases due to external agents (J60.-J70)  
Tip:  
• Exacerbation on COPD shouldn’t be assumed based upon worsening of a concomitant respiratory disease or when COPD is described as end-stage  
• Assign J43.9 when COPD exacerbation with emphysema is documented. |
## Chronic Bronchitis

### ICD-10-CM codes

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</table>
| J44.9          | Chronic obstructive pulmonary disease, unspecified | **Includes:** Chronic obstructive airway disease NOS  
Lung diseases due to external agents (J60-J70)  
**Excludes:** Chronic obstructive lung disease NOS  
Lung diseases due to external agents (J60-J70) |

Use additional code to identify:
- Tobacco dependence (F17.-)
- History of tobacco dependence (Z87.891)
- Tobacco use (Z27.0)
- Exposure to environmental tobacco smoke (Z77.22)
- Occupational exposure to environmental tobacco smoke (Z57.31)
## Chronic Bronchitis

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<tbody>
<tr>
<td>J41.0</td>
<td>Simple chronic bronchitis</td>
<td></td>
</tr>
<tr>
<td>J41.1</td>
<td>Mucopurulent chronic bronchitis</td>
<td></td>
</tr>
<tr>
<td>J41.8</td>
<td>Mixed simple and mucopurulent chronic bronchitis</td>
<td></td>
</tr>
</tbody>
</table>
| J42            | Unspecified chronic bronchitis | • Chronic bronchitis NOS  
• Chronic tracheitis  
• Chronic tracheobronchitis |

Use additional code to identify:
• Tobacco dependence (F17.-)  
• History of tobacco dependence (Z87.891)  
• Tobacco use (Z27.0)  
• Exposure to environmental tobacco smoke (Z77.22)  
• Occupational exposure to environmental tobacco smoke (Z57.31)
## Emphysema

**ICD-10-CM codes**

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<th>Documentation tip</th>
</tr>
</thead>
<tbody>
<tr>
<td>J43.0</td>
<td>Unilateral pulmonary emphysema</td>
<td>Swyer-James syndrome, Unilateral emphysema, Unilateral hyperlucent lung, Unilateral pulmonary artery functional hypoplasia, Unilateral transparency of lung</td>
<td>Use additional code to identify: • Tobacco dependence (F17.-) • Tobacco use (Z27.0) • History of tobacco dependence (Z87.891) • Exposure to environmental tobacco smoke (Z77.22) • Occupational exposure to environmental tobacco smoke (Z57.31)</td>
</tr>
<tr>
<td></td>
<td>[MacLeod’s syndrome]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J43.1</td>
<td>Panlobular emphysema</td>
<td>Panacinar emphysema</td>
<td></td>
</tr>
<tr>
<td>J43.2</td>
<td>Centrilobular emphysema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J43.8</td>
<td>Other emphysema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J43.9</td>
<td>Emphysema, unspecified</td>
<td>Bullous emphysema (lung)(pulmonary) Emphysema (lung)(pulmonary)(NOS) Emphysematous bleb Vesicular emphysema (lung)(pulmonary)</td>
<td></td>
</tr>
<tr>
<td>J98.2</td>
<td>Interstitial emphysema</td>
<td>Mediastinal emphysema</td>
<td></td>
</tr>
<tr>
<td>J98.3</td>
<td>Compensatory emphysema</td>
<td></td>
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</tbody>
</table>
## Chronic Respiratory Failure

### ICD-10-CM

<table>
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</tr>
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<tbody>
<tr>
<td>J96.10</td>
<td>Chronic respiratory failure,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>unspecified whether hypoxia or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>hypercapnia</td>
<td></td>
</tr>
<tr>
<td>J96.11</td>
<td>Chronic respiratory failure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>with hypoxia</td>
<td></td>
</tr>
<tr>
<td>J96.12</td>
<td>Chronic respiratory failure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>with hypercapnia</td>
<td></td>
</tr>
</tbody>
</table>
# Tobacco Use and Dependence

## ICD-10-CM codes

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>F17.20-</td>
<td>Nicotine dependence, unspecified</td>
<td>(-) Add 6(^{th}) character: 0-uncomplicated, 1-in remission, 3-with withdrawal, 8-with other nicotine-induced disorders, 9-with unspecified nicotine-induced disorders</td>
</tr>
<tr>
<td>F17.21-</td>
<td>Nicotine dependence, cigarettes</td>
<td></td>
</tr>
<tr>
<td>F17.29-</td>
<td>Nicotine dependence, other tobacco products</td>
<td></td>
</tr>
<tr>
<td>Z57.31</td>
<td>Occupational exposure to environmental tobacco smoke</td>
<td></td>
</tr>
<tr>
<td>Z72.0</td>
<td>Tobacco use NOS</td>
<td></td>
</tr>
<tr>
<td>Z87.891</td>
<td>Personal history of nicotine dependence</td>
<td></td>
</tr>
</tbody>
</table>
Mr. G. is a 68 y/o male patient that comes to your office today stating his breathing has been worse over the past week. He denies any elevated temperature but is “coughing up” clear/white “phlegm”. Mr. G. has a history of COPD and presently smokes ½ ppd but says he can several days where he may not smoke at all. He says he has been using his inhalers and prescribed and has been using his Albuterol inhaler five or six times a day without any relief.

- **PMH:** Shingles (2018), PSH: Appendectomy (age 15), FMHx: COPD (father)
- **Medications:** Breo Ellipta (Fluticasone/vilantrerol): 1 puff daily, Spiriva (Tiotropium): 1 puff daily and Albuterol MDI (90 mcg/actuation) 2 puffs every 4-6 hours prn.
- **Immunizations:** Prevnar-13 2016, Pneumovax (2018) Influenza Vaccine (2020)
- **Wt.-138 lbs., Ht- 64 inch's, BMI-23.68, B/P 138/88, P-88, R-22, T-98.8 (o), Pulse Ox-92%**
- **Exam reveals:** Mr. Gray is alert and oriented, in no obvious distress but is sitting forward on the exam table with his arms at his sides. HEENT exam is unremarkable. Lungs: decreased breath sounds bilateral lung fields with expiratory wheezes in all lung fields. Heart: RRR w/o murmur. Extremities: no edema, cyanosis or clubbing noted.
- **CXR reveals:** increased bronchovascular markings. Bilateral with flattened hemidiaphragms. A/P view reveals slightly widened A/P diameter. No obvious infiltrates noted.

What would be the most appropriate ICD-10 Dx for Mr G at this visit?

1. Chronic obstructive pulmonary disease with (acute) exacerbation (J44.1) and Tobacco use (Z27.0)
2. Chronic obstructive pulmonary disease (J44.)
3. Emphysema, unspecified (J43.9)
4. Simple chronic bronchitis (J41.0)
IAFP Website for CME attainment 1-2-3

1. Register for a free account

http://cme.iafp.com/
2. Select the training that was performed under the Post-Test and Evaluation tab only and then select the course that was viewed
3. Select the Post-Test & Evaluation. You will be directed to take the exam and proceed with the evaluation. After the exam and evaluation you can print the certificate of completion.
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