ICD-9-CM Coding Guidelines

The below listed pneumonia coding guidelines are not inclusive. The coder should refer to the applicable Coding Clinic guidelines for additional information. The Centers for Medicare & Medicaid Services considers Coding Clinic, published by the American Hospital Association, to be the official source for coding guidelines. Hospitals should follow the Coding Clinic guidelines to assure accuracy in ICD-9-CM coding and DRG assignment.

**Definition of Principal Diagnosis**

The principal diagnosis is that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Two or more diagnoses may equally meet the definition for principal diagnosis as determined by the circumstances of admission, diagnostic work-up and/or therapy provided. Be aware that there is a difference between admitting a patient to treat two conditions and two conditions being present at the time of admission. The principal diagnosis is always the reason for admission.

**Documentation to Support the Diagnosis of Pneumonia**

A diagnosis of pneumonia must be documented by a physician. A coder should not determine the type of pneumonia based on laboratory findings and other information in the medical record without seeking clarification from the physician.

When reviewing the medical record with the diagnosis of pneumonia, note the documentation substantiating pneumonia, including the results of the chest x-ray, sputum culture, white blood cell count, and temperature of the patient. If the record documentation raises questions concerning the diagnosis of pneumonia, query the attending physician.

**Coding Guidelines**

**Aspiration pneumonia**

Be sure the documentation substantiates a diagnosis of pneumonia and not just aspiration. Aspiration pneumonia with growth of Staphylococcus aureus requires two codes. (See Coding Clinic, third quarter 1991, page 16.)

**Candidal pneumonia**

When reviewing Candidal pneumonia, 112.4, be sure the physician has documented Candidal pneumonia. This is often mistakenly coded because a sputum culture was positive for yeast. (See Coding Clinic, second quarter 1998, page 7.)

**Cystic fibrosis with pulmonary manifestations**

As of October 1, 2002, the codes for cystic fibrosis have been expanded to indicate what organs are involved. Cystic fibrosis with pulmonary manifestations is now assigned code 277.02. Cystic fibrosis with gastrointestinal manifestations is now assigned code 277.03. Code 277.03 excludes that with meconium ileus, 277.01. Cystic fibrosis with other manifestations is now assigned code 277.09. (See Coding Clinic, fourth quarter 2002, page 46.) The manifestation involved determines the MDC and DRGs for each cystic fibrosis code.
When a patient with cystic fibrosis, 277.0x is admitted due to a complication, the complication is sequenced as the principal diagnosis and cystic fibrosis is sequenced as a secondary diagnosis. (See Coding Clinic, fourth quarter 2002, pages 45 and 46, and Coding Clinic, fourth quarter 1990, pages 16 and 17.)

**Gram-negative pneumonia**
When the code for gram-negative pneumonia, 482.83, is assigned in the absence of confirmatory cultures, it should be documented in the medical record by the physician as gram-negative pneumonia and the treatment plan should reflect medical care appropriate for a patient with gram-negative pneumonia. (See Coding Clinic, third quarter 1988, page 11.) A gram stain is not conclusive evidence of a gram-negative pneumonia. (See Coding Clinic, second quarter 1998, page 5, and Coding Clinic, first quarter 1994, pages 17 and 18.)

**Gram-positive pneumonia**
When the only diagnostic information available is gram-positive pneumonia, assign code 482.9, bacterial pneumonia, unspecified. (See Coding Clinic, second quarter 1998, page 6.)

**Hemophilus parainfluenza pneumonia**
Hemophilus parainfluenza pneumonia is assigned code 482.83. (See Coding Clinic, third quarter 1994, page 9.) Hemophilus influenza pneumonia is assigned code 482.2.

**Hypostatic pneumonia**
Hypostatic pneumonia is assigned code 514, pulmonary congestion and hypostasis. To code this as bacterial pneumonia requires documentation by the physician. (See Coding Clinic, second quarter 1998, pages 6 and 7.)

**Lobar pneumonia**
Lobar pneumonia and pneumonia of the right lower lobe are not the same. Pneumonia of the right lower lobe without specification is assigned code 486. Lobar pneumonia is a synonym for pneumococcal pneumonia, 481. (See Coding Clinic, March-April 1985, page 6.)

**Mixed bacterial pneumonia**
When the physician documents mixed bacterial pneumonia as the final diagnosis, but does not identify the specific organism, assign code 482.9. Mixed bacterial pneumonia was assigned code 482.8 (per Coding Clinic, third quarter 1988, page 11) until October 1, 1992, when code 482.8 had fifth digits added and the correct code became 482.89. Mixed bacterial pneumonia is assigned code 482.9 for discharges after May 1, 1997. (See Coding Clinic, second quarter 1997, page 6.)

**Oxazolidinone class of antibiotics**
This is a new class of antibiotics used to treat gram-positive bacteria, including resistant gram-positive pathogens. They are reserved for the most medically significant resistant pathogens. They are most commonly assigned for resistant gram-positive infections in conditions such as septicemia, hospital-acquired pneumonia, ventilator-associated pneumonia, post-surgical wounds, traumatic wounds and cellulitis. A new code was created effective October 1, 2002, 00.14, injection or infusion of oxazolidinone class of antibiotics. (See Coding Clinic, fourth quarter 2002, page 95.)

**Pneumonia due to more than one organism**
If the physician states pneumonia is due to more than one organism and the organisms are identified, each type of pneumonia should be coded. (See Coding Clinic, fourth quarter 1993, page 39.)
Pneumonia due to other specified bacteria
Code 482.89 (pneumonia due to other specified bacteria) needs to have an organism cultured that does not code to one of the other bacterial pneumonia codes of 482.0-482.8. (See Coding Clinic, second quarter 1997, page 6.)

Code 482.89 should not be assigned solely on the basis of a gram stain. A sputum gram stain finding of gram-positive cocci is not necessarily indicative of a bacterial pathogen and should not be sequenced as a specified cause of bacterial pneumonia without further chart documentation or definitive sputum cultures. If the physician states the patient had a bacterial pneumonia without further specification, assign code 482.9, bacterial pneumonia, unspecified. If the physician does not specify an etiology, 486, pneumonia, organism unspecified, should be assigned. (See Coding Clinic, first quarter 1994, pages 17 and 18.)

Pneumonia due to SARS
Pneumonia due to severe acute respiratory syndrome (SARS) is assigned code 480.3, pneumonia due to SARS-associated coronavirus, effective October 1, 2003. (See Coding Clinic, fourth quarter 2003, pages 46 and 47.)

Pneumonia/two-day-old infant
If the documentation for pneumonia in a two-day-old infant is unclear whether community-acquired or due to birth process, assign the code from Chapter 15, Conditions in the Perinatal Period. Assign code 770.0 if it is congenital pneumonia. (See Coding Clinic, first quarter 2005, pages 10, 11, and 59-63, and Newborn (Perinatal) Guidelines.)

Postobstructive pneumonia
Postobstructive pneumonia is assigned code 486, pneumonia, organism unspecified, when no cause is documented. If a causative organism of the pneumonia is identified, then the more specific pneumonia code should be assigned. The postobstructive process (i.e., tumor, foreign body, etc.) is also assigned when known. The circumstances of the admission determine the sequencing of the diagnoses. (See Coding Clinic, first quarter 1998, page 8.)

Respiratory failure/Pneumocystis carinii/AIDS
Respiratory failure due to Pneumocystis carinii, which is due to AIDS is assigned code 042, Human Immunodeficiency Virus and sequenced as principal diagnosis. Acute respiratory failure, 518.81, with pneumocystosis, 136.3, are sequenced as secondary diagnoses. Chapter-specific guidelines such as the HIV coding guidelines take precedence over general coding guidelines. (See Coding Clinic, first quarter 2003, page 15.)

Respiratory failure/pneumonia
If the reason for admission is respiratory failure and pneumonia, respiratory failure is sequenced as the principal diagnosis. These conditions are not co-equal. When respiratory failure is documented as being secondary to or associated with a respiratory condition, respiratory failure should be sequenced as the principal diagnosis. The guidelines regarding two or more interrelated conditions meeting the definition of principal diagnosis do not apply since respiratory failure and pneumonia have been specifically addressed in separate Coding Clinic instructions. (See Coding Clinic, second quarter 2003, pages 21 and 22.)

If the medical record indicates the reason for admission is acute respiratory failure for a patient with acute respiratory failure and pneumonia, the principal diagnosis is acute respiratory failure. (See Coding Clinic, November-December 1987, pages 5 and 6.)
**Staphylococcus aureus pneumonia**

Staphylococcus aureus pneumonia is assigned code 482.41 effective October 1, 1998, with the addition of fifth digits to code 482.4, pneumonia due to Staphylococcus. (See *Coding Clinic*, fourth quarter 1998, page 40.)

**Streptococcus pneumoniae pneumonia**

Streptococcus pneumoniae was formerly known as Diplococcus pneumonia and is referred to as pneumococcus. It is the most common cause of community acquired pneumonia and should be assigned code 481, Pneumococcal pneumonia. (See *Coding Clinic*, first quarter 1988, page 13.)