DRG 088 — Chronic Obstructive Pulmonary Disease

ICD-9-CM Coding Guidelines

The below listed chronic obstructive pulmonary disease (COPD) 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 COPD

When reviewing a record with the diagnosis of COPD, identify the medical record documentation that substantiates COPD.

- Chest X-ray
- Arterial blood gases
- Pulmonary function tests
- Dyspnea, breathlessness, tachypnea
- Diffuse wheezing, diminished breath sounds, prolonged expiration
- Chronic productive cough
- Bronchospasm
- Hypoxemia
- Upper respiratory infection, airway inflammation
- Tachycardia

Coding Guidelines

When assigning a code of COPD, chronic bronchitis, acute bronchitis, chronic asthmatic bronchitis, acute asthmatic bronchitis, emphysema, etc., it is important to understand the coding ramifications of the presence of two or more of these conditions and whether or not the condition is acute, chronic or in acute exacerbation.

Acute bronchitis/asthma

Acute bronchitis with asthma is assigned codes 466.0 and 493.90. The acute condition is sequenced first and the chronic condition sequenced second. Asthma is not documented to be exacerbated nor is the patient in status asthmaticus. (DRG 097) (See Coding Clinic, fourth quarter 2004, page 137.)

When assigning codes for acute bronchitis, 466.0 and an exacerbation of asthma 493.92, sequence first the condition requiring the most care or that is the major focus of care. An infectious process, such as acute bronchitis, is not equivalent to an acute exacerbation of asthma. (See Coding Clinic, fourth quarter 2004, page 137.)
Acute bronchitis/COPD
As of October 1, 2004, acute bronchitis with COPD is assigned code 491.22. (See Coding Clinic, fourth quarter 2004, page 81.)

The diagnosis of acute bronchitis with COPD was assigned code 491.21 (see Coding Clinic, volume 10, number 5, 1993, page 5) until October 1, 2003. As of October 1, 2003, 466.0, acute bronchitis, no longer excluded acute bronchitis with COPD, and 491.21, obstructive chronic bronchitis with exacerbation, no longer included the inclusion term acute bronchitis with COPD. (See October 1, 2003 updates for ICD-9-CM.) Therefore, two codes, 491.21 and 466.0, were required to code acute bronchitis with COPD. Code 491.21 was sequenced first. Documentation does not have to specifically state acute exacerbation of COPD. (See Coding Clinic, first quarter 2004, page 3.)

Acute bronchitis/emphysema/chronic obstructive asthma
Acute bronchitis and emphysema are assigned codes 466.0 and 492.8. Acute bronchitis and chronic obstructive asthma are assigned codes 466.0 and 493.2x. (See Coding Clinic, volume 10, number 5, 1993, page 4 [this advice was effective June 11, 1992], and Coding Clinic, fourth quarter 1993, page 41.)

Acute exacerbation of COPD/decompensated COPD
The narrative description for assignment of code 491.21, obstructive chronic bronchitis with (acute) exacerbation, may include COPD in exacerbation, severe COPD in exacerbation, end stage COPD in exacerbation, exacerbation of COPD, COPD with exacerbation, decompensated COPD or decompensated COPD with exacerbation. (See Coding Clinic, third quarter 2002, pages 18 and 19.)

Asthma/COPD
When the diagnoses of asthma and COPD are documented, code 493.2x is assigned. Codes 493.0x, 493.1x and 493.9x are assigned to classify asthma in patients without COPD. As of October 1, 2000, a new fifth-digit of “2”, indicating acute exacerbation, was added to category 493, asthma. As of October 1, 2003, the fifth digit of “0” was revised to unspecified, and the fifth digit of “2” was revised to acute exacerbation. The fifth digit of “2” included acute bronchitis from October 1, 2000, through September 1, 2001. As of October 1, 2001, code 466.0, acute bronchitis, no longer excludes acute bronchitis with asthma, 493.0-493.9 with fifth-digit of “2,” but code 493.2, chronic obstructive bronchitis, excludes acute bronchitis. (See Tabular List in ICD-9-CM; Coding Clinic, fourth quarter 2000, page 42; and Coding Clinic, second quarter 1990, page 20.)

There are many variations in the way asthma and COPD are documented. Code selection must be based on the terms as documented. (See ICD-9-CM Official Guidelines for Coding and Reporting, chapter 8, a. 3.)

Asthmatic bronchitis
Asthmatic bronchitis not specified as chronic is assigned code 493.90. Chronic asthmatic bronchitis was assigned code 491.2x until October 1, 2002, when it was removed from subcategory 491.2, chronic obstructive bronchitis, and moved to subcategory 493.2, chronic obstructive asthma. (See ICD-9-CM coding updates for October 1 2002, and Coding Clinic, November-December 1984, page 17.)

Bronchospasm
Bronchospasm is considered integral to asthma and COPD. Therefore, an additional code of 519.1 would not be assigned. (See Coding Clinic, third quarter 1988, pages 6 and 7.)
**Chronic obstructive bronchitis**
An acute exacerbation of chronic obstructive bronchitis is assigned code 491.21. The assignment of code 466.0, acute bronchitis, in this situation is incorrect. (See Coding Clinic, fourth quarter 1991, pages 24 and 25.)

**Chronic restrictive lung disease**
Chronic restrictive lung disease is assigned code 518.89. (See Coding Clinic, November-December 1987, page 8.)

**COPD on anesthesia evaluation**
A diagnosis of COPD on an anesthesia evaluation signed by the anesthesiologist, can be assigned a code provided there is no conflicting documentation in the medical record and/or the coder is certain COPD is a valid diagnosis. (See Coding Clinic, second quarter 2000, page 15, and Coding Clinic, second quarter 1992, pages 16 and 17.)

**Decompensated COPD**
See “Acute exacerbation of COPD/decompensated COPD.”

**Emphysema/respiratory failure**
A patient with emphysema is admitted to the hospital for acute respiratory failure. The principal diagnosis is acute respiratory failure, 518.81. (See Coding Clinic, first quarter 2005, page 4.)

**Exacerbation of COPD**
COPD with exacerbation without mention of bronchitis is assigned code 491.21. Acute bronchitis with COPD with acute exacerbation only requires one code, 491.22. Acute bronchitis is included in code 491.22 and supercedes the acute exacerbation. (See ICD-9-CM Official Guidelines for Coding and Reporting, 8.b.1 and Coding Clinic, first quarter 2005, page 51.)

As of October 1, 2004, acute bronchitis with COPD is assigned code 491.22.

When the cause of an acute exacerbation of COPD is not identified, code 491.21 is assigned. (See ICD-9-CM coding update for October 1, 1994.) When the cause is identified, the cause is designated as the principal diagnosis. (See Coding Clinic, third quarter 1988, page 5.)

**Mucopurulent bronchitis**
Chronic or recurrent mucopurulent bronchitis is assigned code 491.1. (See Coding Clinic, third quarter 1988, page 12.) Acute or subacute mucopurulent bronchitis is assigned code 466.0. (See ICD-9-CM, index to diseases, and Coding Clinic, third quarter 1988, page 12.)

**Pneumonia/asthma/COPD**
Chronic obstructive bronchitis, 491.20 and pneumonia, 486, are always assigned separate codes. Pneumonia is not an acute exacerbation of COPD. (See Coding Clinic, third quarter 1997, page 9.)

If both asthma and pneumonia are present, each condition should be assigned a code. (See Coding Clinic, first quarter 1992, page 15.)

**Respiratory insufficiency/COPD**
Respiratory insufficiency, 518.82 is integral to COPD and should not be assigned an additional code with chronic obstructive bronchitis, 491.2x, emphysema, 492.x, chronic obstructive asthma, 493.2x or COPD, 496. (See Coding Clinic, second quarter 1991, page 21.)
**Secondary diagnosis/COPD**

Substantiation of COPD as a secondary diagnosis requires documentation in the medical record (history, treatment, anesthesiologist’s anesthesia evaluation, etc.). Any conflicting documentation should be clarified with the attending physician. (See *Coding Clinic*, second quarter 2000, page 15, and *Coding Clinic*, second quarter 1992, pages 16 and 17.)

If the only documentation of COPD is on an x-ray, the finding should be discussed with the attending physician to determine whether or not a code for COPD should be assigned. (See *Coding Clinic*, second quarter 1990, pages 15 and 16.)

**Status asthmaticus**

Status asthmaticus refers to a patient’s failure to respond to therapy administered during an asthmatic episode and is a life threatening complication that requires emergency care. (See *Coding Clinic*, first quarter 2005, page 50.)

A physician must confirm the designation of status asthmaticus before the fifth digit “1” is assigned with codes from category 493. (See *Coding Clinic*, first quarter 1991, page 13, and *Coding Clinic*, third quarter 1988, pages 9 and 10.)

If status asthmaticus is present with any type of COPD or with acute bronchitis, status asthmaticus should be sequenced first. (See *ICD-9-CM Official Guidelines for Coding and Reporting*, 8.a.4 and *Coding Clinic*, first quarter 2005, page 50.)

Only the fifth digit of “1”, with status asthmaticus, is assigned if both status asthmaticus and an acute exacerbation are present. (See *ICD-9-CM Official Guidelines for Coding and Reporting*, 8.a.4 and *Coding Clinic*, first quarter 2005, pages 50 and 51.)