

DOCUMENTATION AND CODING

Asthma and Asthma-Associated Conditions

According to the Centers for Disease Control and Prevention, there are 5.8 million office visits every year in the U.S. for asthma. Accurately and completely coding and documenting asthma, asthma-associated conditions and treatments helps capture our members' health status and promote continuity of care. Below is information for outpatient and professional services from the ICD-10-CM Official Guidelines for Coding and Reporting.

Coding for Asthma and Asthma-Associated Conditions

- Most asthma codes under J45.- describe the condition as "uncomplicated", "with acute exacerbation" or "with status asthmaticus."
- All **known treatments and complications** should be documented.
- A code from **Z79.5-** indicates the patient's long-term (current) use of inhaled steroids and systemic steroids such as prednisone and dexamethasone.
- A statement of "**History of**" indicates the condition is resolved. Avoid using the phrase "history of" for members with active conditions or current treatment.
- When applicable, capture the following codes:
 - Eosinophilic asthma (J82.83)
 - Exposure to environmental tobacco smoke (Z77.22)
 - Exposure to tobacco smoke in the perinatal period (P96.81)
 - History of tobacco dependence (Z87.891)
 - Occupational exposure to environmental tobacco smoke (Z57.31)
 - Tobacco dependence (F17.-)
 - Tobacco use (Z72.0)



When Asthma Intersects with Bronchitis or COPD

- The code J44.89 for COPD includes asthma and COPD. Use an additional code to specify the type of asthma or an
 asthma exacerbation when documented. Do <u>not</u> assign unspecified asthma, uncomplicated (J45.909) as it is not
 considered a type of asthma.
- The code assignment for **unspecified bronchitis without asthma is J40**. The code assignment changes when both asthma and bronchitis are present and varies further with **acuity** and **obstruction**.



Tips to Consider

- Include patient demographics, such as name, date of birth and date of service in all progress notes.
- Document legibly, clearly and concisely.
- Ensure providers sign and date all documents.
- Document how each diagnosis was monitored, evaluated, assessed and/or treated on the date of service.
- Document of the patient's **active treatment** for any past or present diagnosis to help improve continuity of care. This provides a broader scope of conditions impacting member care.
- Note complications with an appropriate treatment plan.
- Take advantage of the Annual Health Assessment or other **yearly preventative exam** as an opportunity to capture conditions impacting member care.

Resources

• ICD-10-CM Official Guidelines for Coding and Reporting, Chapter 10: Diseases of the Respiratory System (J00-J99) and Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

The material presented here is for informational/educational purposes only, is not intended to be medical advice or a definitive source for coding claims and is not a substitute for the independent medical judgment of a physician or other health care provider. Health care providers are encouraged to exercise their own independent medical judgment based upon their evaluation of their patients' conditions and all available information, and to submit claims using the most appropriate code(s) based upon the medical record documentation and coding guidelines and reference materials. References to other third-party sources or organizations are not a representation, warranty or endorsement of such organization. Any questions regarding those organizations should be addressed to them directly.