

FOCUS ON: Pulmonary fibrosis

Pulmonary fibrosis is when the lung tissue around and between the air sacs (alveoli) becomes scarred and damaged, causing thickened, stiff lung tissue. This makes it harder for oxygen to pass through the walls of the air sacs into the bloodstream, making the individual progressively more short of breath. Once the lung tissue becomes scarred, the damage cannot be reversed. About 140,000 Americans have been diagnosed with pulmonary fibrosis. It is most likely to affect people ages 50 to 75. In most cases, there is no known cause for the disease; this is referred to as idiopathic pulmonary fibrosis or IPF.

Things that may increase the risk of pulmonary fibrosis include; cigarette smoking, exposure to environmental toxins or pollutants, radiation therapy to lungs or breast and certain medications. Lung damage can also occur from certain medical conditions including; GERD, SLE, Rheumatoid arthritis, sarcoidosis, scleroderma, TB and pneumonia.¹

Chronic obstructive pulmonary disease (COPD) is the third leading cause of death in America and has been diagnosed in nearly 13 million adults. Researchers estimate another 12 million may have COPD but have not yet been diagnosed.² COPD is a serious but highly preventable disease; smoking is the leading cause of COPD in the U.S. COPD is an umbrella term for the diagnosis of emphysema and chronic bronchitis. Chronic asthma also puts individuals at higher risk of developing COPD. The definite diagnosis of COPD is made using a spirometry test, to measure how well the lungs are working. Providers should document and code the specific type of COPD when known; emphysema, chronic bronchitis or chronic asthma rather than the default code of COPD.

Documentation and coding tips

- For pulmonary fibrosis document and code other external agent (**J60-J70**) or radiation therapy
- Specify any acute exacerbation or status asthmaticus
 - An acute exacerbation, acute lower respiratory infection is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.
- If a patient is on long-term oxygen, document the clinical condition that supports the use of oxygen, the status and the treatment plan

Coding pulmonary fibrosis

- **J84.10** Pulmonary fibrosis, unspecified
- **J84.112** Idiopathic pulmonary fibrosis

Coding chronic obstructive pulmonary disease (COPD)

Code also type of asthma, if applicable (J45.-)

- **J44.0** Chronic obstructive pulmonary disease with acute lower respiratory infection
Code also to identify the infection
- **J44.1** Chronic obstructive pulmonary disease with (acute exacerbation)
- **J44.9** Chronic obstructive pulmonary disease, unspecified

Coding emphysema

- **J43.9** Emphysema, unspecified

Coding chronic bronchitis

- **J41.0** Simple chronic bronchitis (smoker's cough)
- **J41.1** Mucopurulent chronic bronchitis
- **J41.8** Mixed simple and mucopurulent chronic bronchitis
- **J42** Unspecified chronic bronchitis

Coding chronic asthma

- J45.909 Unspecified asthma, uncomplicated
- J45.902 Unspecified asthma with status asthmaticus
- J45.901 Unspecified asthma with (acute) exacerbation

For codes J00-J99, use additional code to identify:

- Exposure to environmental tobacco smoke (Z77.22)
- History of tobacco dependence (Z87.891)
- Occupational exposure to environmental tobacco smoke (Z57.31)
- Tobacco dependence (F17.-)
- Tobacco use (Z72.0)

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2019: "A dash (-) at the end of an alphabetic index entry indicates that additional characters are required. Even if a dash is not included at the alphabetic index entry, it is necessary to refer to the tabular list to verify that no 7th character is required." The bolding of the ICD-10-CM codes represents categories, subcategories or codes that map to the CMS-HCC risk adjustment model for payment year 2019.

This guidance is to be used for easy reference; however, the ICD-10-CM code book and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the "thought process" of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment, and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. Lastly, on April 2, 2018, the Centers for Medicare & Medicaid Services (CMS) announced that 2018 dates of service for the 2019 payment year model is based on 100% of the 2019 CMS-HCC model mappings released April 2, 2018. See: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>

For additional information as well as publications and products available for HEDIS[®], please visit the National Committee for Quality Assurance (NCQA) website at ncqa.org. For additional information about the Medicare Advantage Five-Star Quality Rating System, please refer to: <http://go.cms.gov/partcanddstarratings>.

Optum360 ICD-10-CM: Professional for Physicians 2019. Salt Lake City, UT: 2018.

1. "Introduction to Pulmonary Fibrosis." American Lung Association. 2018. Web 12 Sept 2018. <<http://www.lung.org/lungdisease/pulmonary-fibrosis/understanding-pulmonary.html>>

2. "How Serious is COPD" American Lung Association. 2018. May 2014. Web 12 Sept 2018. <<http://www.lung.org/lung-health-and-diseases/lung-disease-lookup/copd/learn-about-copd/how-serious-is-copd.html>>.