CODES and TIDBITS

The Medical Coding Academy Monthly Newsletter

The lungs are the major organs of the respiratory system which function is to mainly remove carbon dioxide and bring oxygen to the blood.

Chronic obstructive pulmonary disease (COPD) is a common lung disease causing restricted airflow and breathing problems.

COPD is the third leading cause of death worldwide, causing 3.23 million deaths in 2019. COPD is the seventh leading cause of poor health worldwide. Tobacco smoking accounts for over 70% of COPD cases in high-income countries. In LMIC tobacco smoking accounts for 30–40% of COPD cases, and household air pollution is a major risk factor.

In this month's **Codes and Tidbits** newsletter, your medical coding experts from the Medical Coding Academy write about the COPD.

The Medical Coding Academy team also celebrates our training experts recently passing the CCS exam!

Melanie, VP of Coding Education

Donna, Training Manager of Medical Coding Academy

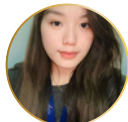**Joanna,** Training Supervisor of Medical Coding Academy

Nercy, Training Supervisor of Medical Coding Academy

Shanda, Home Health Coding and Outpatient Coding Training Expert

Celine, Risk Adjustment Coding and Outpatient Coding Training Expert

Rae, Inpatient Coding Coding Training Expert

THIS ISSUE'S FEATURED ARTICLES:

CODES and TIDBITS

The Medical Coding Academy Monthly Newsletter

WHAT'S WHAT

by Melanie Kiss, *VP of Coding Education*

Chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus (sputum) production and wheezing. It's typically caused by long-term exposure to irritating gases or particulate matter, most often from cigarette smoke. People with COPD are at increased risk of developing heart disease, lung cancer and a variety of other conditions. (COPD - Symptoms and causes - Mayo Clinic)

When coding COPD, coders must be aware of the symptoms that are commonly associated with COPD since they will not be coded separately. Here's a list of the common symptoms:
- Shortness of breath
- Wheezing
- Chest tightness
- Chronic cough
- Lack of energy

Since COPD is such a prevalent disease, it's important that coders are very familiar with the Official Coding Guidelines regarding coding of COPD. This newsletter will provide the necessary education to ensure proper coding. Be sure to read it in its entirety and enjoy the education!
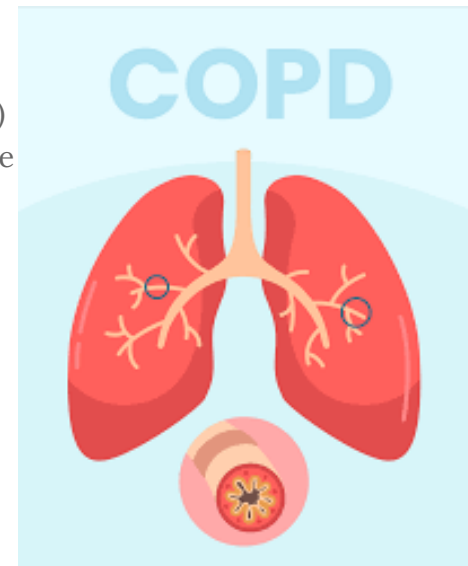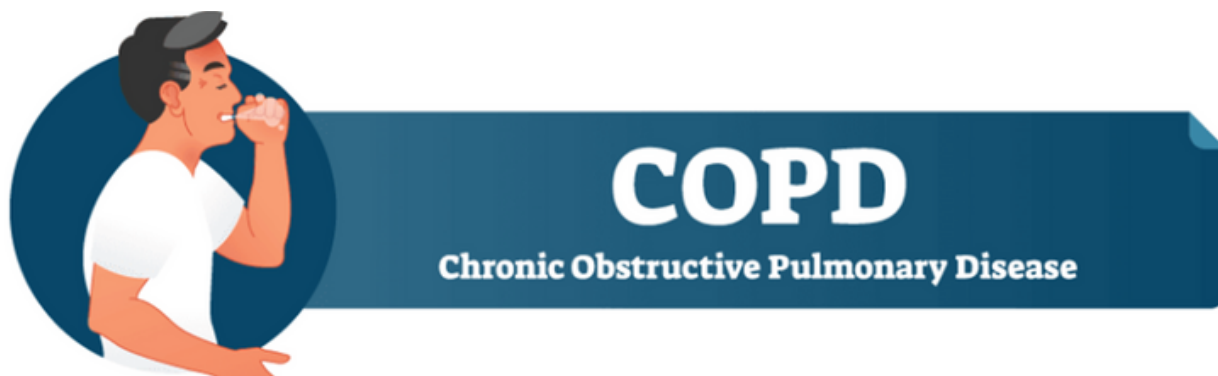
CODES and TIDBITS

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DID YOU KNOW?

by Rae Dela Cruz, *Inpatient Coding Training Expert*

COPD
Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is a common lung disease causing restricted airflow and breathing problems. It is sometimes called emphysema or chronic bronchitis.
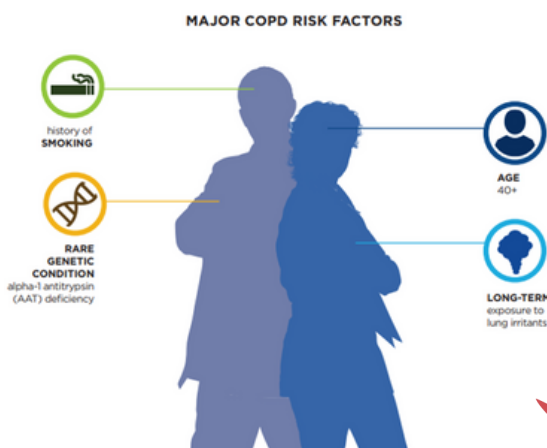
In people with COPD, the lungs can get damaged or clogged with phlegm. Symptoms include cough, sometimes with phlegm, difficulty breathing, wheezing and tiredness.

Smoking and air pollution are the most common causes of COPD. People with COPD are at higher risk of other health problems.

COPD is not curable, but symptoms can improve if one avoids smoking and exposure to air pollution and gets vaccines to prevent infections. It can also be treated with medicines, oxygen, and pulmonary rehabilitation.

Most often, COPD occurs in people aged 40 and over who...
- Have a history of smoking.
- Have had long-term exposure to lung irritants such as air pollution, chemical fumes, or dust from the environment or workplace.
- Has a rare genetic condition called alpha-1 antitrypsin (AAT) deficiency?
- Have a combination of any of the above

MAJOR COPD RISK FACTORS

history of **SMOKING**

RARE GENETIC CONDITION
alpha-1 antitrypsin (AAT) deficiency

AGE 40+

LONG-TERM exposure to lung irritants

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DID YOU KNOW? (CONTINUED)

To understand what COPD is, we first need to understand how respiration and the lungs work:

Breathing in
When you breathe in, or inhale, your diaphragm contracts and moves downward. This increases the space in your chest cavity, and your lungs expand into it. The muscles between your ribs also help enlarge the chest cavity. They contract to pull your rib cage both upward and outward when you inhale.

As your lungs expand, air is sucked in through your nose or mouth. The air travels down your trachea, or windpipe, and into your lungs. After passing through your bronchial tubes, the air travels to the alveoli, or air sacs.

Gas exchange
Every time you breathe in, oxygen from the air you inhale passes through the thin walls of the alveoli into the surrounding capillaries, where red blood cells pick it up using a protein called hemoglobin. At the same time, carbon dioxide, the waste gas carried back to the lungs from the cells of the body, trades places with the oxygen, moving from the blood in the capillaries back to the alveoli.

GAS EXCHANGE IN A LUNG

bronchial tubes/ airways

alveoli/ air sacs
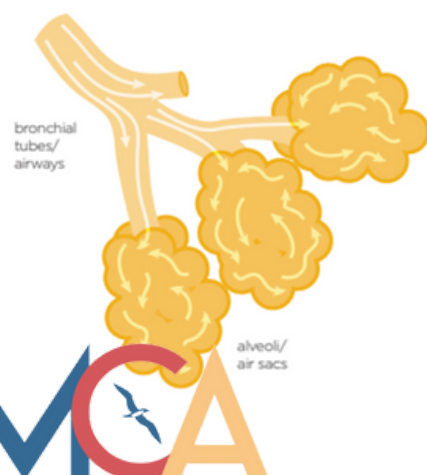
Blood with oxygen-rich red blood cells travels to the heart through the pulmonary veins. The heart then pumps the oxygenated blood to the body, where it moves from your blood vessels to your cells. The cells need this oxygen to make the energy your body needs to work. When cells make that energy, they create the waste product carbon dioxide. That carbon dioxide must be removed from the blood and the body, which is why it is pushed from the cells back to the blood.

The carbon dioxide, once in the bloodstream, travels back to the heart, where it enters the right side. From there, it travels through the pulmonary artery to the lungs, where it flows from the capillaries back into the alveoli in exchange for the incoming oxygen. From the alveoli, the carbon dioxide is breathed back out.

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DID YOU KNOW? (CONTINUED)

Breathing out

When you breathe out, or exhale, your diaphragm and rib muscles relax, reducing the space in the chest cavity. As the chest cavity gets smaller, your lungs deflate, like how air releases from a balloon. At the same time, carbon dioxide-rich air flows out of your lungs through the windpipe and then out of your nose or mouth.

Breathing out requires no effort from your body unless you have a lung disease or are doing physical activity. When you are physically active, your abdominal muscles contract and push your diaphragm against your lungs even more than usual. This rapidly pushes air out of your lungs.

How COPD affects breathing

In COPD, the airways of the lungs (bronchial tubes) become inflamed and narrowed. They tend to collapse when you breathe out and can become clogged with mucus. This reduces airflow through the bronchial tubes, a condition called airway obstruction, making it difficult to move air in and out of the lungs. The inflammation of the bronchial tubes makes the nerves in the lungs very sensitive. In response to irritation, the body forces air through the airways by a rapid and strong contraction of the muscles of respiration—a cough. The rapid movement of air in the breathing tubes helps remove mucus from the lungs into the throat. People with COPD often cough a great deal in the morning after a large amount of mucus has built up overnight (smoker's cough). The lungs are where the blood picks up oxygen to deliver throughout the body and where it disposes of carbon dioxide that is a by-product of the body's processes. COPD affects this process.

**COPD DECREASES AIR FLOW AND GAS EXCHANGE IN THE LUNGS**

bronchial tubes/ airways

alveoli/ air sacs

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DID YOU KNOW? (CONTINUED)

Types of COPD

- **Emphysema** can lead to destruction of the alveoli, the tiny air sacs that allow oxygen to get into the blood. Their destruction leads to the formation of large air pockets in the lung called bullae. These bullae do not exchange oxygen and carbon dioxide like normal lung tissue. Also, the bullae can become very large. Normal lung tissue next to the bullae cannot expand properly, reducing lung function.

- **Chronic bronchitis** affects the oxygen and carbon dioxide exchange because the airway swelling, and mucus production can also narrow the airways and reduce the flow of oxygen-rich air into the lung and carbon dioxide out of the lung. The damage to the alveoli and airways makes it harder to exchange carbon dioxide and oxygen during each breath. Decreased levels of oxygen in the blood and increased levels of carbon dioxide cause the breathing muscles to contract harder and faster. The nerves in the muscles and lungs sense this increased activity and report it to the brain. As a result, you feel short of breath.
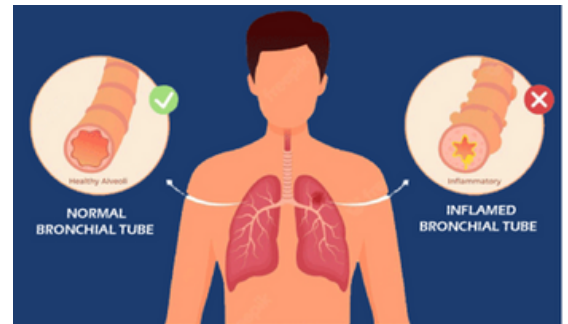
## Are You Missing the Early Warning Signs?

You may think having a cough that brings up sputum or experiencing shortness of breath is a normal part of aging. To reduce having these unpleasant symptoms occur, you may start to change your day-to-day activities and without thinking about it become less active. As your lung function worsens, it becomes harder to breathe, remain active and continue to do the things you enjoy. However, treatment is available to help reduce symptoms, so you remain active and independent. **Early detection is key to potentially preventing COPD progression while reducing symptoms and improving your quality of life.**

CODES and TIDBITS

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DID YOU KNOW? (CONTINUED)

Common Signs and Symptoms of COPD

COPD SYMPTOMS — Chest Tightness, Cough and Sputum, Chronic Dyspnea, Whezzing, Weight Loss
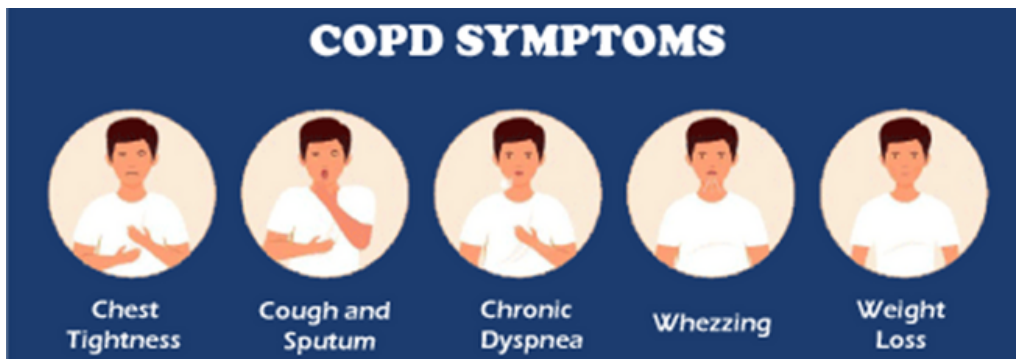
- Chronic cough
- Shortness of breath (dyspnea)
- Coughing up sputum
- Wheezing or chest tightness
- Fatigue or tiredness
- Unable to take a deep breath.
- Weight loss
- Feel like you cannot breathe.

COPD is diagnosed based on

- Signs and symptoms: chronic cough, excess sputum
- Personal and medical history: smoking history or exposure to lung irritants, such as secondhand smoke, air pollution, chemical fumes, or dust
- Test results: lung function tests, spirometry Lung function tests measure how much air is breathed in and out, how fast air is breathed out, and how well lungs deliver oxygen to the blood.

The main lung function test for COPD is spirometry which can detect COPD before symptoms become severe. It is a simple, non-invasive breathing test that measures the amount of air a person can blow out of the lungs (volume) and how fast he or she can blow it out. The test helps detect COPD and its severity and can also find out whether other conditions, such as asthma or heart failure, are causing the symptoms.

CODES and TIDBITS

The Medical Coding Academy Monthly Newsletter

DID YOU KNOW? (CONTINUED)

Treatment and management of COPD

Many people with COPD have mild forms of the disease for which little therapy is needed other than smoking cessation. Even for more advanced stages of disease, effective therapy is available that can control symptoms, slow progression, reduce your risk of complications and exacerbations, and improve your ability to lead an active life.

Medications
- Bronchodilators: Albuterol (ProAir HFA, Ventolin HFA, others)
- Inhaled Steroids: Fluticasone (Flovent HFA)
- Combination inhalers: (Fluticasone and vilanterol (Breo Ellipta)
- Oral steroids
- Phosphodiesterase-4 inhibitors
- Theophylline
- Antibiotics

Lung therapies
- Oxygen Therapy
- Pulmonary Rehabilitation Program
- In- home noninvasive ventilation therapy: BiPAP

Lifestyle changes
- Quitting smoking
- Avoiding lung irritants, such as smoke and pollutants

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CAN YOU CODE ACCURATELY?

by Shanda Salting, *Home Health and Outpatient Coding Training Expert*

Here's last issue's correct code assignment. Did you get it right?

	Codes	Code description
Principal Diagnosis	H69.83	Other specified disorders of Eustachian tube, bilateral
Secondary Diagnosis	H65.196	Other acute nonsuppurative otitis media, recurrent, bilateral
Secondary Diagnosis	H65.33	Chronic mucoid otitis media, bilateral
Secondary Diagnosis	H90.0	Conductive hearing loss, bilateral
Secondary Diagnosis	J35.2	Hypertrophy of adenoids
CPT Code 1	69436 - 50	Tympanostomy (requiring insertion of ventilating tube), general anesthesia, bilateral procedure
CPT Code 2	42830	Adenoidectomy, primary; under age 12

HPI: A 56-year-old male patient is in the ER with increased work of breathing. He felt mildly short of breath after waking this morning but became extremely dyspneic after climbing a few flights of stairs. He is even too short of breath to finish full sentences. His wife is present in the room and revealed that the patient has a history of liver failure, is allergic to penicillin, and has a 15-pack-year smoking history. She also stated that he builds cabinets for a living and is constantly required to work around a lot of fine dust and debris.

Past Medical History: Liver Failure, right sided Heart Failure Hypertension and Diabetes

Social History: He was a cigarette smoker.

Allergies: Penicillin

Medication list: Metformin, Lisinopril, Coreg

Physical Findings
Vital Signs: Heart rate: 92 beats/min; SpO2: 84%; Respiratory rate: 22 breaths/min
HEENT: His pupils are equal and reactive to light. He is alert and oriented. He is breathing through pursed lips. His trachea is positioned in the midline, and no jugular venous distention is present.

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The Medical Coding Academy Monthly Newsletter

CAN YOU CODE ACCURATELY? (CONTINUED)

Chest: He has a larger-than-normal anterior-posterior chest diameter. He demonstrates bilateral chest expansion. He demonstrates a prolonged expiratory phase and diminished breath sounds during auscultation. He is showing signs of subcostal retractions. Chest palpation reveals no tactile fremitus. Chest percussion reveals increased resonance.
Abdomen: His abdomen is soft and tender. No distention is present.
Extremities: His capillary refill time is two seconds. Digital clubbing is present in his fingertips. There are no signs of pedal edema. His skin appears to have a yellow tint.

Lab and Radiology Results
ABG results: pH 7.35 mmHg, $PaCO_2$ 59 mmHg, HCO_3 30 mEq/L, and PaO_2 64 mmHg.
Chest x-ray: Flat diaphragm, increased retrosternal space, dark lung fields, slight hypertrophy of the right ventricle, and a narrow heart.
Blood work: RBC 6.5 mill/m3, Hb 19 g/100 mL, and Hct 57%.

Diagnosis:
Based on the information given, the patient has exacerbation of chronic obstructive pulmonary disease (COPD).

Management:
The treatment for this patient was to initiate with low flow oxygen administration with an FiO_2 of 28% via air-entrainment mask. This improved the patient's condition. He was discharged with a recommendation for home oxygen therapy if the patient's PaO_2 drops below 55 mmHg or their SpO_2 drops below 88% more than twice in a three-week period. Albuterol and Budesonide were also prescribed.

Feel free to send in your answers to MedicalCodingAcademyTrainingTeam@swhealth.com – the correct code assignment will be released in the next Codes and Tidbits issue!
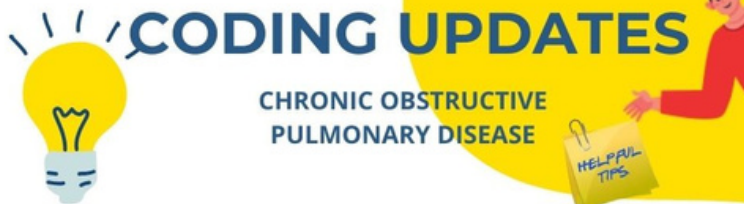
CODES and TIDBITS

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TALK CODING TO ME

by Celine Villadares, *Risk Adjustment and Outpatient Coding Training Expert*

Talk Coding To Me is an article that provides you coding tips, tricks, and best practices from your Medical Coding Academy Team.

CODING UPDATES

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

HELPFUL TIPS

Chronic obstructive pulmonary disease, or COPD, refers to a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis.

Emphysema and chronic bronchitis are the two most common conditions that contribute to COPD. These two conditions usually occur together and can vary in severity among individuals with COPD.

With the recent release of ICD-10-CM Guidelines for 2024, J44 Category Code, Other chronic obstructive pulmonary disease, has noted changes when it comes to listed Excludes 1 & 2.

2024 ICD-10-CM Tabular list now listed the following under J44:

Excludes2: bronchiectasis (J47.-)
emphysema without chronic bronchitis (J43.-)

This has also noted changes in the category code J43, Emphysema which previously has J44 under excludes 1. For the changes in Official Coding Guideline FY 2024, it is noted:

J43 Emphysema

Excludes1: compensatory emphysema (J98.3)
emphysema due to inhalation of chemicals, gases, fumes or vapors (J68.4)
interstitial emphysema (J98.2)
mediastinal emphysema (J98.2)
neonatal interstitial emphysema (P25.0)
surgical (subcutaneous) emphysema (T81.82)

Excludes2: emphysema with chronic (obstructive) bronchitis (J44.-)
emphysematous (obstructive) bronchitis (J44.-)
traumatic subcutaneous emphysema (T79.7)

! This means that J43, J44 and J47 can now be coded together if documented!

Happy Coding!

Resources:
ICD-10-CM Tabular List of Disease and Injuries, Official Coding Guideline FY 2024, page 619-620

Centers for Disease Control and Prevention

CODES and TIDBITS

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TALK CODING TO ME

by Joanna Adriano, *Training Supervisor of Medical Coding Academy*

Chronic obstructive pulmonary disease (COPD) is a general term used to describe a variety of conditions that result in obstruction of the airway. COPD is a progressive lung disease, which gets worse over time. ICD-10-CM classifies these conditions to category J44, Other chronic obstructive pulmonary disease. Category J44 includes the following conditions:

- Asthma with chronic obstructive pulmonary disease
- 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

Category J44 is further subdivided to specify whether there is an acute lower respiratory infection (J44.0) and whether there is an exacerbation of the condition (J44.1). If applicable, a code from category J45 is assigned to specify the type of asthma.

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TALK CODING TO ME (CONTINUED)

In the case of code J44.0, Chronic obstructive pulmonary disease with (acute) lower respiratory infection, a code should also be assigned to identify the infection. Code J44.0 is assigned for COPD with acute bronchitis or pneumonia, but not for COPD with influenza, because influenza involves both upper and lower respiratory infections.

The codes in category J44 distinguish between uncomplicated cases (J44.9) and those with acute exacerbation (J44.1). An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, although an exacerbation may be triggered by an infection. For example, COPD with acute bronchitis should be coded to J44.0, rather than J44.1. Examples of the terms classified to J44.1, Chronic obstructive pulmonary disease with (acute) exacerbation, are "exacerbation," "in exacerbation," "decompensated," "acute exacerbation," "exacerbated," or "uncompensated."

When the diagnosis is stated only as COPD, review the medical record to determine whether a more definitive diagnosis is documented. Code J44.9, Chronic obstructive pulmonary disease, unspecified, is assigned only when a more specific code cannot be assigned.

In addition to codes in category J44, codes may also be assigned 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.-), or tobacco use (Z72.0).

Note that emphysema without chronic bronchitis is coded to category J43.-, Emphysema is a chronic lung disease caused by damage to the alveoli, the tiny air sacs within the lung where the exchange of oxygen and carbon dioxide takes place.

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TALK CODING TO ME (CONTINUED)

Bronchitis is an inflammation of the lining of the bronchial tubes, which carry air to and from the lungs. Chronic bronchitis not otherwise specified is classified to J42.

Asthma characterized as obstructive or diagnosed in conjunction with COPD is classified to category J44, Other chronic obstructive pulmonary disease. Code also the type of asthma (J45.-) only when the specific type of asthma is documented by the provider. If the documentation does not specify the type of asthma, do not assign code J45.909, Unspecified asthma, uncomplicated. "Unspecified" is not a type of asthma.
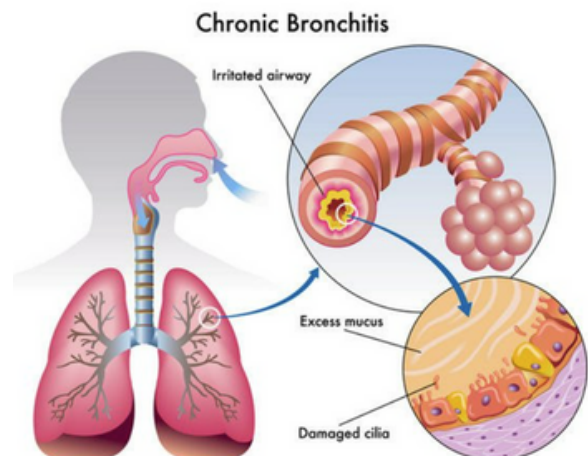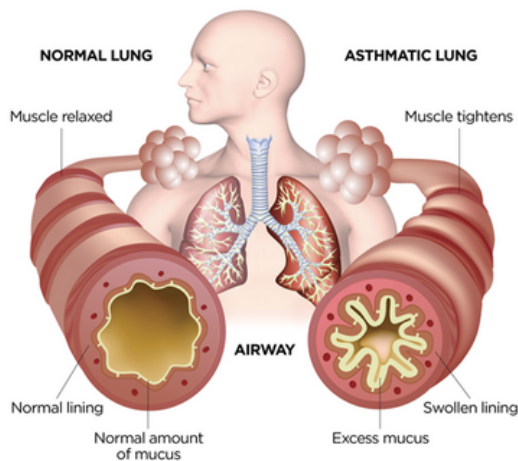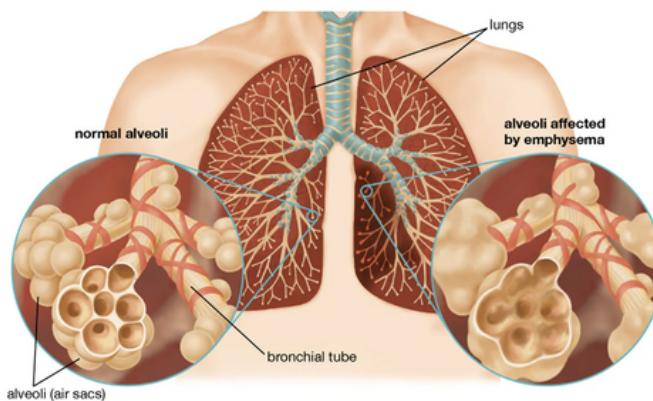
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INCREDIBLE CODING DIVA (ICD)

by Donna Abigail Della, *Training Manager of Medical Coding Academy*

Our Incredible Coding Diva for September 2023 is none other than **Sharie Madarang** from Training!

Read below as Sharie shares her career story – starting as a Medical Coding Academy scholar and then working her way up to be a Coding Training Specialist.

Sharie, tell us something about yourself.
I am a graduate of BSN from the University of Santo Tomas. After passing the board exams, I immediately applied as a Staff Nurse in UST Hospital and worked there for 13 years. I am also a USRN but the plans of migrating to the US changed when I got married and had children. I enjoy cooking for my family and travelling.

How long have you been with Shearwater Health?
I was a part of a batch that was enrolled to an affiliate coding review center and later endorsed to Shearwater in April 2022 where I signed a contract and officially became an MCA Scholar. I have been with Shearwater for 1 year and 6 months now.

What has your experience been with our company culture?
Shearwater is true to their word about associate's career growth. When I attended the new hire orientation with Sir EJ Magat, there was a part of the discussion where we were asked to map out our career path. This gave me the chance to set my mind and envision myself better in this industry.

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INCREDIBLE CODING DIVA (ICD) (CONTINUED)

Where were you before Shearwater Health?
I was a fulltime mom. I decided to take a step back from my professional career and focus on my family. This was also the time when I was able to enroll and complete a formal baking and cake decorating courses from Treston University and Heny Sison, respectively. Aside from this, I also learned coffee roasting and latte art, taking my love for coffee to a higher level.

What was the moment you knew you'd made the right decision to work here?
I knew that I made the right decision working here when I felt the life-work balance. I can work while my kids are in school. I can still prepare meals for them even after work hours. And rest on weekends fully, not thinking of being called to work like when I was still a Staff Nurse.

What is your favorite thing about working in Shearwater Health?
Shearwater is very generous in giving incentives and paid time offs (PTOs). I am also very lucky to have supportive and gorgeous colleagues from the wonderful Training Team.

What are you most proud of?
Being a mother to 6 children, maintaining a household while at the same time, being able to mentor and guide young and new coders. This is fulfilling for me, both professionally and as a lifelong learner.

CODES and TIDBITS

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INCREDIBLE CODING DIVA (ICD) (CONTINUED)

Tell us about your career progression
After completing the Medical Coding Academy program and passing the CCS exam, I was aligned to a pioneer IP account, Idaho, led by Ms. Rae Dela Cruz. We would have weekly huddles facilitated by Sir Chris and I was in awe with how he handled the coding education to our team. This is when I decided that if I want to progress in this career, I want to be mentored by Sir Chris. And then a position for Training Specialist opened in our account. I felt that I wasn't ready yet, but it was Ms. Rae's reassuring words that brought me to where I am now.

How have you benefited from Medical Coding Academy?
I wanted to be able to apply my knowledge in Nursing but not work on a clinical setting. So when I learned about the opportunity for MCA, I knew it was the perfect fit for me. MCA opened the door for me to start a new career, have a stable job, and to continue learning. I have since learned the foundations of Inpatient Coding - which to this day is still the basis for all codes that we are capturing.

Can you describe how you felt when you start the MCA program?
I felt at ease because it was a work from home setup. My trainers at the time, Ms. Nercy and Sir Jham, were also very supportive from the start of the review up to the day of our CCS exam.

Is there a particular moment or memory that stands out for you while in the program?
That nerve-wracking moment when I finished the CCS exam and had to walk straight from the testing room to the receptionist waiting for me to get the test result.

CODES and TIDBITS

The Medical Coding Academy Monthly Newsletter

INCREDIBLE CODING DIVA (ICD) (CONTINUED)

What was your life like before joining MCA? How is your life like now?

Being an introvert myself, I was limiting myself to my family and friends. But I also felt that I could do so much more, and that I should widen my reach. Being a trainer now, I have a sense of purpose in sharing what I've learned so far in the industry. This sharing also becomes more meaningful for me when I see an impact to the associates that I'm reaching my help to.

What advice would you give to someone starting out in Medical Coding Academy?
Your hard work will pay off and I could attest to that.

What would you say to other medical-allied professionals facing the same challenges as you did?
Don't give up!

What an inspiring story!!! Thank you for sharing it with us, Sharie! You are a proof that a woman can do it all! Keep up that fighting spirit and never stop learning! Your MCA family is proud of you!

CODES and TIDBITS

The Medical Coding Academy Monthly Newsletter

CELEBRATING VICTORIES WITH MCA

by Donna Abigail Della, *Training Manager of Medical Coding Academy*

This new section of the Codes and Tidbits newsletter is dedicated in celebrating victories of the Medical Coding Academy Team!

And what better way to launch this than celebrating the Medical Coding Academy Training Experts in successfully getting certified with the CCS coding license! Not only did they prepare for the exam just by themselves, but they were able to do that while simultaneously handling multiple MCA classes.

You have made everyone proud, Joanna, Nercy, Shanda, and Celine!! **CONGRATULATIONS!!**