**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.

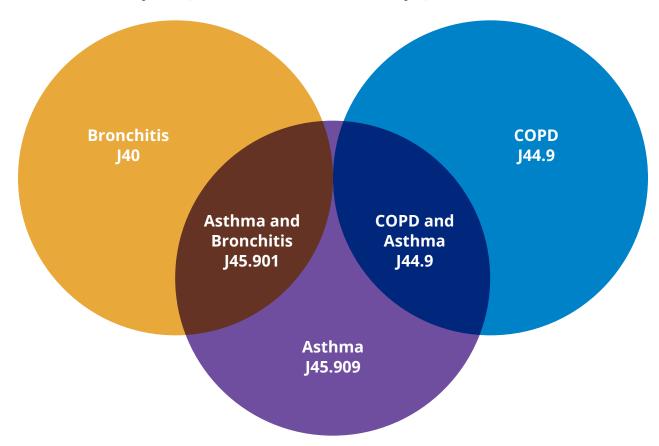
# **Coding for Asthma and Asthma-Associated Conditions**

- The codes in categories **J44** and **J45** distinguish between uncomplicated cases and those in acute exacerbation.
- All known treatments and complications should be documented.
- A code from **Z79.5x** 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. Don't document "History of" for members with active conditions or current treatment.

Sample ICD-10-CM Codes for Asthma, Associated Conditions and Treatments	
Mild intermittent asthma	J45.2-
Mild persistent asthma	J45.3-
Moderate persistent asthma	J45.4-
Severe persistent asthma	J45.5
Bronchitis, not specified as acute or chronic	J40
Asthma with bronchitis	J45.901
Chronic Obstructive Pulmonary Disorder (COPD) (includes unspecified asthma with COPD)	J44.9
Long-term (current) use of inhaled steroids	Z79.51
Long-term (current) use of systemic steroids	Z79.52

#### When Asthma Intersects with Bronchitis or COPD

- The code J44.9 for COPD includes asthma and COPD.
- Asthma and bronchitis (J45.901) is a different code than bronchitis (J40).



### **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 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. The fact that a service or treatment is described in this material, is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.