Acuity Documentation:
COPD

Best Practice: Document with M.E.A.T.

Monitor
- Review signs and symptoms
- Review logs (blood sugar, BP)
- Disease progression/regression noted

Evaluate
- Reviewing lab/test results
- Review of diagnostic tests
- Medication/treatment effectiveness
- Relevant physical examination

Assess/ Address
- Stable, improving, worsening, etc.
- Discussion/counseling
- Exacerbation of condition
- Relevant record review

Treat
- Referral to specialist
- Adjusting, refilling, prescribing medication
- Surgical procedures

Noting any one of the M.E.A.T criteria will satisfy the documentation requirements needed to code that condition on a claim

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M.E.A.T. Documentation Keywords:

Assessment	Plan
Stable	Monitor
Improved	D/C meds
Tolerating meds	Continue meds
Deteriorating	Refer to / Followed by

Examples:

- COPD currently stable on Flovent.
- Patient is being seen today for exacerbation of COPD; patient uses oxygen at home.

COPD Key Points

Document and report COPD at any visit where it factors into the medical decision making.

Be sure the documentation & DX code match, and the correct condition in the COPD family is indicated/reported

- Asthma
- Emphysema
- Bronchitis
- COPD

Documentation Tips:

- Document condition by name and indicate the acuity/ severity levels.
  - Acute/Chronic/Intermittent
  - Chronic w/ acute exacerbation
  - Mild, moderate, or severe
- Be sure to document & report the type of COPD correctly:
  - Chronic Asthma
  - COPD
  - Chronic Bronchitis
  - Emphysema
- If a specialist is following the condition more closely indicate that in the documentation.
  - i.e., Patient sees Dr. Smith for COPD, condition currently stable.
- Be sure to include all associated conditions, complications, or co-morbidities.
  - Heart Disease
  - Pulmonary HTN
  - OSA
- Notate any oxygen use, tobacco status, bronchodilator, or steroid use and add associated code

Common ICD-10 Codes

ICD-10	Description
J44.0	COPD with acute lower respiratory infection
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified
J41.0	Simple chronic bronchitis
J42	Unspecified chronic bronchitis
J45.21	Mild intermittent asthma w/ acute exacerbation (note: not an HCC)
J45.901	Unspecified asthma with (acute) exacerbation (note: not an HCC)
J45.909	Asthma, uncomplicated (note: not an HCC)
J96.10	Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
J43.1	Panlobular emphysema
J43.9	Emphysema, unspecified

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Other Common Associated Codes

ICD-10	Description
Z99.81	Oxygen dependence
Z72.0	Tobacco use
F17.200	Nicotine dependence
Z87.891	Personal history of nicotine dependence
Z79.52	Long term (current) use of steroids

Keeping Compliant Documentation

- Completeness and accuracy is always our goal!
- Never document or bill diagnoses that are not present or currently being treated
- Never up-code diagnoses to achieve a higher risk score
- Do not document a resolved or historical medical condition as current if it is no longer being treated
- Correct any errors in diagnoses previously reported or that no longer apply
- Keep accurate, specific problem lists to easily pull the most appropriate codes into encounter notes
- Avoid using abbreviations unless the condition is previously established in the documentation within the same OV note.

Case Studies

Case Sample #1

HPI: “Pt in for 4-month f/up of COPD and DMII. Quit smoking 2 years ago. BS not well controlled at home per BS log kept by patient and diabetic neuropathy with itching and formication's is worse on current Neurontin.”

Assessment:

- Type 2 diabetes with worsening diabetic neuropathy;
- Hyperglycemia
- Stable COPD

Plan:

- Increase Neurontin to 300mgm BID.
- Additional regular insulin 4 units BID.
- Maintain current dosage of Spiriva

- ✓ J44.9 Chronic Obstructive Pulmonary Disease, unspecified
- ✓ E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
- ✓ Z87.891 History of tobacco use
- ✓ Z79.4 Long term use of insulin
- ✓ E11.65 Diabetes II with hyperglycemia

Case Sample #2

HPI: "Patient comes in with c/c of productive, persistent cough > 1-week, post-URI. She feels SOB with minimal exertion. Has diabetes from chronic steroids and takes insulin to control BS daily."

PE: Decreased breath sounds and right lower lung rales consistent with acute broncho-pneumonia infection in right lower lobe.

Assessment:

- COPD with acute bronchitis
- Diabetes secondary to medication stable

Plan:

- Keflex 500mgm PO BID
- Continue chronic Breo dosage for next week;
- RTC in 1 week for re-assessment

- ✓ J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
- ✓ E09.9 Drug or chemical induced Diabetes without complications
- ✓ J20.9 Acute bronchitis, unspecified
- ✓ Z79.51 Long term use of inhaled steroids
- ✓ Z79.4 Long term use of insulin

Case Sample #3

HPI: "John in for f/up for HBP and CKD stage 4 stable; saw Dr. Barry last week. Patient feels emphysema is deteriorating. Oxygen not providing as much relief as before. Continued difficulty with SOB with even short walks."

PE: Decreased BS bilaterally; O2Sat 88% on 2L continuous oxygen

Assessment:

- HTN CKD stage 4 stable
- Emphysema minimal increase in SOB

✓I12.9 Hypertensive chronic kidney disease with stage 1 through 4 CKD
✓N18.4 Chronic kidney disease, stage 4
✓J43.9 Emphysema, unspecified
✓Z99.81 Dependence on supplemental oxygen