



J00, "Acute nasopharyngitis"

Once you understand a few peculiarities, you'll be ready to code common diseases of the respiratory system.

Coding Common Respiratory Problems in ICD-10

Kenneth D. Beckman, MD, MBA, CPE, CPC

"Diseases of the Respiratory System" (J00-J99), perhaps more than any other chapter in ICD-10, leaves room for physicians to make a judgment call about how to code certain conditions. Before we get into the codes themselves, let's explore a few confounding factors:

1. Symptom vs. diagnosis. With the exception of streptococcal pharyngitis and tonsillitis, a specific infectious agent causing a disease is rarely identified at the time of the initial visit. ICD-10 allows you to report signs or symptoms (R00-R99) when you have not yet established or confirmed a related definitive diagnosis; however, sometimes what seems like a sign or symptom might actually be considered a diagnosis in ICD-10. Take "sore throat" for example. Code R07.0, "Pain in throat," specifically *excludes* "sore throat (acute)," but J02.9, "Acute pharyngitis, unspecified," specifically *includes* "sore throat (acute)." Therefore, it appears that ICD-10 considers "sore throat" to be a definitive diagnosis rather than a symptom.

2. Acute vs. acute recurrent. In ICD-9, codes were divided into "acute" and "chronic" conditions. In ICD-

10, there is the additional classification of "acute recurrent." In the absence of specific definitions, you must use your judgment to determine the time frame between episodes that would qualify a condition as "acute recurrent." Your documentation will need to support whichever classification you use.

3. Inflammation vs. infection. Although the suffix "itis" references *inflammation*, the conditions pharyngitis, tonsillitis, sinusitis, etc., are all subcategories under "Acute upper respiratory *infections*" (J00-J06) in ICD-10. So, when you see an inflammation that is not from an infection, you need to look for a more specific code.

4. Multiple sites vs. the lower anatomic site. ICD-10 instructs that when a respiratory condition is documented as occurring in more than one site and there is not a specific code for that condition, it should be classified to the lower anatomic site. The example the ICD-10 book provides is tracheobronchitis being coded as bronchitis (J40).

5. Unspecified vs. lacking specific documentation. Although ICD-10 includes unspecified codes such as J06.9, "Acute upper respiratory infection, unspecified,"

About the Author

Dr. Beckman is a family physician, former chief medical officer, and consultant with The Beckman Group in Milwaukee, Wis. Author disclosure: no relevant financial affiliations disclosed.

ICD-10 considers “sore throat” to be a definitive diagnosis rather than a symptom.

to avoid claim denials think carefully before using them. The use of unspecified codes is discouraged if you’re using them because of a lack of clinical documentation.

6. Tobacco vs. no tobacco. ICD-10 requires that if tobacco is a factor in any illness, you must add the appropriate code from the F or Z series to identify current use, history of use, or exposure. (See “Tobacco use or exposure codes.”) Given the frequency of smoking as a causative agent in respiratory

conditions, you’ll want to keep these tobacco codes in mind.

Now that you are aware of these idiosyncrasies, which can affect both your documentation and your coding, let’s navigate through the respiratory system.

Acute nasopharyngitis

Ready for some good news? The common cold is still the common cold and has a simple, three-digit ICD-10 code: J00, “Acute nasopharyngitis.” ICD-10 even includes “common cold” in the description.

Sinusitis

The ICD-10 codes for sinusitis align fairly well with those in ICD-9. Both sets include maxillary, frontal, ethmoidal, and sphenoidal. ICD-10 adds the option of pansinusitis. In ICD-9, pansinusitis fell under “Other”; however in ICD-10, “Other acute sinusitis” (J01.80) is for infections involving more than one sinus but not pansinusitis. Both ICD-9 and ICD-10 include a code for unspecified.

Each of the acute sinusitis codes requires a fifth digit that differentiates “acute” from “acute recurrent.” The chronic codes have only four digits. (See “Sinusitis codes.”)

If the cause of the sinusitis is known, add a code from B95-B97, “Bacterial and viral infectious agents,” to identify the infectious agent.

Clinical scenario: A 62-year-old female presents to your office with classic symptoms of sinusitis. She has no known risk factors other than sharing a household with her husband who smokes in the residence. On examination, you are able to elicit tenderness over the maxillary sinuses only. You place her on a two-week course of oral antibiotics and assign code J01.00.

After completing the antibiotics, she returns with persistent symptoms. She is now tender over both the frontal sinuses as well as the maxillary sinuses. You prescribe a different antibiotic for a longer course and arrange to see her again in four weeks. The condition

TOBACCO USE OR EXPOSURE CODES

Nicotine dependence	
Unspecified	F17.20*
Cigarettes	F17.21*
Chewing tobacco	F17.22*
Other tobacco product	F17.29*
Tobacco use (problems related to lifestyle)	Z72.0
Exposure to environmental tobacco smoke – occupational	Z57.31
Exposure to environmental tobacco smoke (second-hand smoke exposure and passive smoking)	Z77.22
Personal history of nicotine dependence	Z87.891

See a previous discussion of these codes in: Beckman KD. How to document and code for hypertensive diseases in ICD-10. *Fam Pract Manag.* 2014;21(2):5-9. <http://www.aafp.org/fpm/2014/0300/p5.html>.

*Note: Code requires a sixth character:

- 0, uncomplicated,
- 1, in remission,
- 3, with withdrawal,
- 8, with other specified nicotine-induced disorder,
- 9, with unspecified nicotine-induced disorder.

SINUSITIS CODES

	Acute sinusitis	Acute recurrent sinusitis	Chronic sinusitis
Maxillary	J01.00	J01.01	J32.0
Frontal	J01.10	J01.11	J32.1
Ethmoidal	J01.20	J01.21	J32.2
Sphenoidal	J01.30	J01.31	J32.3
Pansinusitis	J01.40	J01.41	J32.4
Other	J01.80	J01.81	J32.8
Unspecified	J01.90	J01.91	J32.9

PHARYNGITIS CODES

Streptococcal pharyngitis	J02.0
Acute pharyngitis due to other specified organisms	J02.8
Acute pharyngitis, unspecified	J02.9
Chronic nasopharyngitis	J31.1
Chronic pharyngitis	J31.2

is not yet recurrent or chronic, so you assign code J01.80, “Other sinusitis, acute,” which is for infections involving more than one sinus. You also document the second-hand smoke exposure using Z77.22, “Contact with and exposure to environmental tobacco smoke.”

On her follow-up visit, her condition has completely resolved.

Three months later, she again presents with maxillary sinusitis. Because she has gone a significant period of time without signs or symptoms, you use the acute recurrent code J01.01.

Pharyngitis

The pharyngitis codes are also pretty straightforward. The condition can be acute or chronic and due to streptococcus, due to a known agent other than streptococcus, or unspecified. (See “Pharyngitis codes.”) Three additional causes of acute pharyngitis that may be identified in the primary care office are excluded from this category: gonococcus (A54.5), herpes (B00.2), and mononucleosis (B27.-). These codes are typically used for a follow-up visit after the results of previously ordered labs are available.

Tonsils and adenoids

This group of codes, like the sinus codes, includes acute, acute recurrent, and chronic codes. It also includes a set of codes for non-infectious conditions. In a similar manner to ICD-9, there are separate codes for abscess and for hypertrophy. Adenoid vegetations had a stand-alone code in ICD-9, but this condition was merged into “Other chronic diseases of tonsils and adenoids” in ICD-10. (See “Tonsil and adenoid codes.”)

Clinical scenario: A 4-year-old male is brought in to your office with an acute sore throat. A rapid strep test is positive, and

TONSIL AND ADENOID CODES

	Infectious	Non-infectious
Adenoiditis, chronic	J35.02	
Adenoids, hypertrophy		J35.2
Tonsillitis		
Acute streptococcal	J03.00	
Acute recurrent streptococcal	J03.01	
Acute, due to other specified organism	J03.80	
Acute recurrent, due to other specified organism	J03.81	
Acute, unspecified	J03.90	
Acute recurrent, unspecified	J03.91	
Chronic	J35.01	
Peritonsillar abscess	J36	
Tonsils, hypertrophy		J35.1
Tonsillitis and adenoiditis, chronic	J35.03	
Tonsils and adenoids		
Hypertrophy		J35.3
Other chronic diseases		J35.8
Chronic disease, unspecified		J35.9

you place him on an appropriate course of penicillin. You code the visit J03.00.

He presents two months later in the same manner with the same result. You again treat him but now use the recurrent code J03.01.

He has two additional episodes over the next four months.

At his 5-year-old preventive care examination, you note that he has significant enlargement of his tonsils and adenoids. You do not detect any sign of a current infection or abscess. You code the visit using Z00.121, “Encounter for routine child health examination with abnormal findings” (primary) and J35.3, “Hypertrophy of tonsils with hypertrophy of adenoids” (secondary).

Larynx, trachea, and epiglottitis

These codes include acute (with or without obstruction) and chronic codes, but there are no acute recurrent codes. The unspecified codes do not differentiate between the larynx and trachea but use the term “Supraglottitis.” (See “Larynx, trachea, and epiglottitis codes,” page 20.)

Note that while tracheitis and supraglottitis are divided into “with” and “without obstruc-

tion” by the use of a fifth digit, acute obstructive laryngitis (croup) has a stand-alone four-digit code, J05.0.

Hopefully, you will rarely see acute epiglottitis in the office, but be aware that there are codes for this condition without obstruction (J05.10) and with obstruction (J05.11).

There are separate codes for noninfectious

In ICD-10, many codes include not only “acute” and “chronic” classifications but also “acute recurrent.”

If there is no definitive diagnosis or evidence of infection for a patient’s respiratory problem, consider a symptom code.

For infective rhinitis, use code J00 (common cold), but for chronic, vasomotor, and allergic rhinitis use codes in the J30-J31 range.

VOCAL CORD AND LARYNX CODES

Paralysis	
Unspecified	J38.00
Unilateral	J38.01
Bilateral	J38.02
Polyp	J38.1
Nodules of vocal cords	J38.2
Edema of larynx	J38.4
Laryngeal spasm	J38.5

RHINITIS AND OTHER CODES RELATED TO THE NOSE

Rhinitis	
Infective	J00
Chronic	J31.0
Vasomotor	J30.0
Allergic rhinitis	
Due to pollen	J30.1
Other seasonal	J30.2
Due to food	J30.5
Due to animal hair and dander	J30.81
Other	J30.89
Unspecified	J30.9
Nasal polyps	J33.0
Deviated nasal septum	J34.2
Hypertrophy of nasal turbinates	J34.3

LARYNX, TRACHEA, AND EPIGLOTTIS CODES

	Acute	Chronic
Laryngitis	J04.0	J37.0
Tracheitis without obstruction	J04.10	
Tracheitis with obstruction	J04.11	
Laryngotracheitis	J04.2	J37.1
Supraglottitis without obstruction	J04.30	
Supraglottitis with obstruction	J04.31	

conditions, such as those related to the vocal cords and larynx. (See “Vocal cord and larynx codes.”)

Clinical scenario: A 40-year-old female presents to your office on Monday morning. She has an important business presentation later in the week and can barely speak. She gives you the history that her twin daughters were in a soccer tournament over the weekend and she spent two days cheering incessantly. She had no preceding symptoms of a viral upper respiratory infection. Your examination shows diffuse erythema of the larynx and vascular engorgement of the vocal folds. You recommend voice rest and adequate hydration and provide reassurance.

Your first thought is to code this as acute laryngitis, J04.0; however, this code falls in the J00-J06 range titled “Acute upper respiratory infections” and you see no evidence that this is an infective laryngitis. Therefore, you look up “hoarseness” in the ICD-10 index, and this takes you to R49.0, “Dysphonia.”

Nose

There are a few codes specific to the nose that you will commonly encounter in primary care. Infective rhinitis defaults to the “Acute nasopharyngitis” (common cold) J00 code, discussed earlier. However, chronic rhinitis gets its own code, J31.0. Vasomotor and allergic rhinitis also have their own code series (J30). (See “Rhinitis and other codes related to the nose.”)

Clinical scenario: A father brings his 8-year-old daughter to your office because of allergy symptoms. He tells you that every fall she develops sneezing, a runny nose, and itchy eyes. The symptoms are worse when she is outdoors. The family recently adopted a dog from the local shelter, but the girl’s symptoms do not seem worse.

You make a diagnosis of allergic rhinitis and discuss conservative care including the use and overuse of decongestants and antihistamines.

You suspect this condition may be caused by pollen but have not performed allergy testing. The his-

Remember that ICD-10 does not prohibit you from using your clinical judgment, but your documentation must support your judgment.

tory suggests it is not related to the new pet or to food. You cannot use the “Other allergic rhinitis” code because it is used when the etiology is known but not listed in ICD-10. Therefore, you select J30.9, “Allergic rhinitis, unspecified.”

This is an example of the correct use of an “unspecified” code. It is being used per ICD-10 guidelines “when the information in the medical record is insufficient to assign a more specific code.” However, if in your clinical judgment the condition is caused by pollen, you need to document that judgment in the record and then assign code J30.1, “Allergic rhinitis due to pollen.”

Remember that ICD-10 does not prohibit you from using your clinical judgment, but your documentation must support your judgment.

Bronchitis and bronchiolitis

These two conditions are commonly encountered in the primary care office, but documenting the causative organism is rare, with the

exception of J20.5, “Acute bronchitis due to respiratory syncytial virus” (RSV), in a pediatric patient. Therefore, you’ll typically use just two ICD-10 codes: J20.9 and J21.9. (See “Bronchitis and bronchiolitis codes.”)

Influenza and pneumonia

As we move further down the respiratory tract, the likelihood of a primary care physician using diagnostic codes that specify the causative organism decreases, particularly in the office setting. When you make a clinical diagnosis of influenza in the office, coding will reflect an *unidentified* influenza virus. Therefore, depending on the presence of any additional findings, you will likely use one of several codes for “Influenza due to unidentified influenza virus.” (See “Influenza codes.”)

For influenza NOS (not otherwise specified), ICD-10 directs you to use J11.1. There are multiple additional codes for identified influenza virus infections, including novel A types (avian, swine, etc.).

Community-acquired pneumonia is often a clinical diagnosis based on the history and physical examination, with no radiologic confirmation typically required or recommended on initial presentation. If your medical record documents findings consistent with pneu-

Use “Other allergic rhinitis” when the etiology is known but not listed in ICD-10; use “Allergic rhinitis, *unspecified*” when the etiology is unknown.

Your clinical judgment and documentation are key to your code selection.

When you make a clinical diagnosis of influenza in the office setting, your coding will likely reflect an *unidentified* influenza virus.

BRONCHITIS AND BRONCHIOLITIS CODES

Acute bronchitis, unspecified	J20.9
Acute bronchiolitis, unspecified	J21.9

INFLUENZA CODES

Influenza due to unidentified influenza virus	
With unspecified type of pneumonia	J11.00
With other respiratory manifestations	J11.1
With gastrointestinal manifestations	J11.2
With otitis media	J11.83
With other manifestations	J11.89

PNEUMONIA CODES

Pneumonia, unspecified organism	J18.9
Additional clinical findings:	
Bronchopneumonia, unspecified organism	J18.0
Lobar pneumonia, unspecified organism	J18.1
Hypostatic pneumonia, unspecified organism	J18.2
Other pneumonia, unspecified organism	J18.8
Positive sputum culture:	
Viral pneumonia	J12.0 - J12.9
Bacterial pneumonia	J13 - J17

EMPHYSEMA/COPD CODES

Emphysema	J43.X
Other COPD	J44.X
COPD, unspecified	J44.9

ASTHMA CODES

	Uncomplicated	With (acute) exacerbation	With status asthmaticus
Mild intermittent	J45.20	J45.21	J45.22
Mild persistent	J45.30	J45.31	J45.32
Moderate persistent	J45.40	J45.41	J45.42
Severe persistent	J45.50	J45.51	J45.52
Unspecified	J45.909	J45.901	J45.902

monia, you should code the visit as such rather than using sign and symptom codes. Remember that your clinical judgment and medical record documentation are the key elements that support your coding determination. In most cases, only one ICD-10 code will be applicable: J18.9, “Pneumonia, unspecified organism.”

Clinical findings might allow for increased coding specificity. In addition, there are numerous ICD-10 codes that should be used if a positive sputum culture has been documented. (See “Pneumonia codes,” page 21.)

Emphysema/COPD

For these conditions, ICD-10 uses two base code categories: J43 for emphysema and J44 for chronic obstructive pulmonary disease (COPD). All codes require a fourth digit. However, without additional testing, it is unlikely that a primary care physician can clearly differentiate emphysema from chronic bronchitis. Per the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health, “Most people who have COPD have both emphysema and chronic bronchitis. Thus, the general term ‘COPD’ is more accurate.”¹ In

that case, J44.9, “COPD, unspecified,” should be used. (See “Emphysema/COPD codes.”)

Asthma

Classification of asthma is based on the NHLBI’s “Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma” published in 2007. Coding is based on the classification level and the presence of an acute exacerbation or status asthmaticus. (See “Asthma codes.”)

Clinical scenario: A 23-year-old female presents to your office as a new patient. She states she is having problems with her asthma. Her past history included daily symptoms prior to being started on a low-dose inhaled corticosteroid with the need for short-acting beta agonist daily. With the use of the medications, her asthma had been well controlled prior to developing upper respiratory infection symptoms three days earlier. You make the diagnosis of an acute exacerbation of moderate persistent asthma (J45.41) and treat her accordingly.

At a follow-up visit one week later, she is symptom-free and tells you she has returned to her baseline status. An office FEV1 (test of forced expiratory volume in one second) is reduced about 5 percent. You confirm her diagnosis of moderate persistent asthma and code the visit using J45.40.

More to come

This completes our tour of the respiratory system codes. In the next installment in this series (see “Articles in *FPM*’s ICD-10 series”), we’ll head south and review documentation and coding for gastrointestinal disorders common in primary care. **FPM**

1. Chronic obstructive pulmonary disease (COPD) quiz answers. NHLBI website. <http://1.usa.gov/1r7lqHy>. Accessed May 27, 2014.

ARTICLES IN *FPM*’S ICD-10 SERIES

You can access the following articles in *FPM*’s ICD-10 topic collection: <http://www.aafp.org/fpm/icd10>.

“ICD-10 Simplifies Preventive Care Coding, Sort Of,” *FPM*, July/August 2014.

“ICD-10 Coding for the Undiagnosed Problem,” *FPM*, May/June 2014.

“How to Document and Code for Hypertensive Diseases in ICD-10,” *FPM*, March/April 2014.

“10 Steps to Preparing Your Office for ICD-10 – Now,” *FPM*, January/February 2014.

“Getting Ready for ICD-10: How It Will Affect Your Documentation,” *FPM*, November/December 2013. (Includes a section on diabetes mellitus codes.)

“The Anatomy of an ICD-10 Code,” *FPM*, July/August 2012.

“ICD-10: What You Need to Know Now,” *FPM*, March/April 2012.

Send comments to fpmedit@afp.org, or add your comments to the article at <http://www.aafp.org/fpm/2014/1100/p17.html>.