

Clinical overview

Definition¹

Chronic obstructive pulmonary disease (COPD) is a broad term that represents a group of chronic, progressive lung diseases that obstruct the airways in the lungs, making it difficult to breathe. There is no cure for COPD, and lung damage caused by COPD is not reversible. Conditions related to COPD include but are not limited to asthma, bronchiectasis, pulmonary hypertension, obstructive sleep apnea, lung cancer and cardiovascular disease.

Types²

There are two main types of COPD, and most people with COPD have a combination of both conditions:

- Emphysema (slowly progressive destruction of the lung tissue, which loses its elasticity and ability to expand and contract)
- Chronic bronchitis (long-term, chronic inflammation and cough with mucus, resulting in narrowing and blockage of the airways)

Causes/Risk factors¹

- Smoking (No.1 cause)
- Long-term exposure to environmental irritants (e.g., toxic fumes, dust, air pollution, secondhand smoke, etc.)
- History of serious respiratory infections

Signs and symptoms²

- Chronic cough or cough with large amounts of mucus
- Shortness of breath that is worse with exertion
- Wheezing and chest tightness

Complications³

- Frequent respiratory infections (e.g., influenza and pneumonia)
- Heart problems
- Lung cancer

Diagnostic tools²

- Pulmonary function tests (PFTs) and pulse oximetry (Measures oxygen saturation in the blood. Generally, values under 90% are considered low.)
- Imaging tests (chest X-ray, CT scan, MRI)
- Arterial blood gas (ABG) analysis

Treatment⁴

- Smoking cessation and avoidance of environmental irritants
- Medications (linked to diagnosis) and immunizations (e.g., influenza, pneumonia, and others)
- Oxygen therapy and pulmonary rehabilitation

Best documentation practices for healthcare providers

Subjective

- The HPI sets the background for the patient's presenting problem, from when the condition was first diagnosed until this encounter.
- May include Review of Systems (ROS), Past, Family, and/or Social History (PFSH), Active Problems List.
- Document the presence of any current symptoms related to chronic obstructive pulmonary disease (e.g., shortness of breath, cough, fatigue, etc.). If there are no current symptoms, this section should document the patient was screened for symptoms.

Objective

Document any objective data to include physical exam findings (e.g., decreased breath sounds, wheezing, etc.) and related diagnostic test results, such as PFTs.

Assessment/Impression

COPD is a chronic, systemic condition that almost always affects patient care, treatment or management. Therefore, it is appropriate to document the COPD diagnosis in the final assessment as a current, coexisting condition, even in the absence of specific treatment of the condition on an individual date of service.⁵

Plan

- Document a clear and concise treatment plan for COPD, linking related medications to the diagnosis.
- Include orders for diagnostic testing, specialist referral(s) or consultation requests
- Address any additional steps being taken to treat the patient.⁶

Coding tips

COPD with coexisting asthma

COPD with unspecified asthma is included in category J44 and codes to J44.89. If the type of asthma is not specified, only J44.89 is assigned. When the type of asthma is further specified, two codes are assigned: A code from category J44 for COPD; and a code from category J45 to report the type of asthma. Subcategories under J45 include the following:

- J45.2 Mild intermittent asthma
- J45.3 Mild persistent asthma
- J45.4 Moderate persistent asthma
- J45.5 Severe persistent asthma
- J45.9 Other and unspecified asthma

Fifth and sixth characters are added to report whether asthma is uncomplicated, with exacerbation or with status asthmaticus.

COPD with exacerbation of asthma codes to J44.89 and J45.9Ø1, Unspecified asthma with (acute) exacerbation. Although code J45.9Ø1 does not represent a type of asthma, it is needed to identify asthma is in acute exacerbation.⁷

When a medical record documents both acute exacerbation of asthma AND status asthmaticus, only the code for the more severe condition (status asthmaticus) should be assigned.

COPD with exacerbation and acute bronchitis

Code J44.1, COPD with exacerbation, has an *Excludes2* note advising code J44.Ø (COPD with acute bronchitis) is not part of the condition represented by code J44.1. This indicates it is acceptable to assign both codes when the medical record shows both conditions are present. The record does not have to specifically state the exacerbation is acute to assign code J44.1, as "acute" is enclosed in parentheses as a nonessential modifier. "Acute" is inherent to exacerbation.

COPD with acute bronchitis (an acute infection) is coded:

- J44.Ø Chronic obstructive pulmonary disease with (acute) lower respiratory infection
- J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
- J2Ø.9 Acute bronchitis, unspecified⁸

COPD with bronchiectasis

A causal association between COPD and bronchiectasis has not yet been clinically proven, but it is biologically plausible that COPD could be the cause of bronchiectasis, and they may coexist.⁹

Emphysema

Emphysema classifies to category J43. A fourth character is required to specify the particular type of emphysema. Please note that emphysema can coexist with COPD.

Additional reminders

- Pneumonia is not an acute exacerbation of COPD. When these two conditions coexist, code separately.
- Hypoxia is not inherent in COPD. When COPD is documented with hypoxia, code RØ9.Ø2, Hypoxemia, may be assigned as an additional diagnosis.
- COPD does not automatically mean chronic bronchitis.
- Effective 10/01/2023, per ICD-10-CM Official guidelines for coding and reporting, the **Excludes1** notes at category J44 regarding codes J47.- and J43.- have been changed to **Excludes2** notes which now includes bronchiectasis (J47.-) and emphysema without chronic bronchitis (J43.-) when the medical record supports that both conditions are present.¹⁰
- When performing retrospective coding reviews, be certain to use coding software or the ICD-10-CM coding manual that correlates with the date of service being reviewed.

DOS 10/01/2023-05/31/2024	Excludes 1 note changed to Excludes 2 note allowing J43-, J44- & J47- to be coded together
DOS 06/01/2024-09/30/2026	Excludes 2 note allowing J43-, J44- & J47- to be coded together when COPD is further specified (i.e., with infection or with acute exacerbation). ¹¹

Coding examples

Example 1	
Medical record documentation	<p>DOS: 12/21/2024</p> <p>The patient is a 68-year-old male presenting for routine follow-up of COPD, specifically emphysema. The patient reports increased shortness of breath on exertion over the past month but denies any acute exacerbations or chest pain.</p> <p>Past medical history: COPD, emphysema, hypertension Social history: Former smoker Physical exam: Lungs: Decreased breath sounds bilaterally, no wheezes or crackles</p> <p>Assessment & plan: Emphysema – stable, no acute exacerbation. Continue tiotropium inhaler daily and albuterol as needed. Follow-up in 3 months</p>
ICD-10-CM codes	<ul style="list-style-type: none"> • J43.9 Emphysema, unspecified
Rationale	<p>Assign only code J43.9, Emphysema, unspecified, for a patient with COPD and emphysema. No additional code for COPD is assigned unless it is further specified (i.e., with infection or with acute exacerbation). Code J43.9 can be referenced in the Alphabetic Index as follows: Disease, diseased -lung</p>

	--obstructive(chronic) ---with ----emphysema J43.9 ¹¹
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Example 2	
Medical record documentation	<p>DOS: 08/01/2025</p> <p>68-year-old male with a history of COPD and bronchiectasis who presents with worsening dyspnea, increased cough, and thicker, yellowish sputum over the past several days. Past Medical History: COPD, bronchiectasis</p> <p>Physical Examination: Vital Signs: BP 128/80, HR 78, RR 18, Temp 98.6°F, SpO2 92% on room air General: Mild respiratory distress Lungs: Decreased breath sounds bilaterally, scattered wheezing</p> <p>Assessment & Plan: COPD with acute exacerbation, bronchiectasis, chronic. Will start Oxygen therapy, Nebulized bronchodilators every 4 hours, prescribed antibiotics and requesting pulmonology consult.</p>
ICD-10-CM codes	<ul style="list-style-type: none"> • J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation • J47.9 Bronchiectasis, uncomplicated
Rationale	Based on the clinical documentation of an acute exacerbation, it is advisable to assign both ICD-10 codes J44.1 (Chronic obstructive pulmonary disease with acute exacerbation) and J47.9 (Bronchiectasis, uncomplicated) to accurately reflect a COPD exacerbation in the presence of chronic bronchiectasis. ¹²

Example 3	
Medical record documentation	<p>DOS: 10/02/2024</p> <p>76-year-old male presents for 3-month follow-up of chronic obstructive pulmonary disease and asthma. He admits to occasional wheezing and persistent cough. Patient states his prescribed inhaler provides some relief.</p> <p>Vital Signs: BP 128/76, HR 88, RR 20, Temp 98.2°F, SpO₂ 94% on room air General: Alert, in no acute distress Lungs: Decreased breath sounds bilaterally, occasional expiratory wheezes, no rales</p> <p>Assessment & Plan: 1. COPD, stable 2. Asthma, partially controlled Continue current inhaled corticosteroid/long-acting beta agonist (ICS/LABA) inhaler. Increase use of rescue inhaler (albuterol) as needed, not exceeding prescribed frequency. Follow up in 3 months or sooner if symptoms worsen</p>
ICD-10-CM codes	<ul style="list-style-type: none"> • J44.89 Other specified chronic obstructive pulmonary disease
Rationale	Assign code J44.89, Other specified chronic obstructive pulmonary disease, for a patient with asthma and COPD. A separate code for asthma should not be assigned unless the type of asthma is specified, or the asthma is exacerbated.
Rationale	The instructional note under category J44, Other chronic obstructive pulmonary disease, states "code also type of asthma, if applicable (J45-)." Therefore, it would be appropriate to separately report a code for the specific type of asthma and/or asthma exacerbation when documented. Although asthma exacerbation does not specify a type of asthma, it does provide additional specificity (acuity) regarding the asthma. Do not assign code J45.909, Unspecified asthma, uncomplicated, when the type of asthma is not further specified. "Unspecified" is not considered a type of asthma. ¹³

Example 4	
Medical record documentation	<p>DOS: 09/02/2024</p> <p>65-year-old female with a history of chronic COPD and asthma who presents today with complaints of worsening respiratory symptoms. The patient reports increased shortness of breath, cough productive of yellow sputum. Symptoms began five days ago, progressively worsening.</p> <p>Past Medical History: COPD, asthma Medications: Albuterol inhaler as needed</p> <p>Physical Examination: Vital Signs: Temp 99.7 F, HR 92, BP 134/78, RR 18, SpO2 93% on room air General: Mild respiratory distress Lungs: Diffuse expiratory wheezes, crackles at bases, prolonged expiratory phase</p> <p>Assessment: Acute exacerbation of COPD, acute bronchitis, acute exacerbation of asthma Plan: Medications prescribed, continue albuterol every four hours as needed. Monitor respiratory status closely; return to clinic or ED if worsening. Schedule follow-up in 5-7 days</p>
ICD-10-CM codes	<ul style="list-style-type: none"> • J44.0 COPD with acute lower respiratory infection • J20.9 Acute bronchitis, unspecified • J44.1 COPD with (acute) exacerbation • J45.901 Unspecified asthma with (acute) exacerbation
Rationale	<p>COPD with acute bronchitis codes to J44.0. Code J44.0 advises to use an additional code to identify the infection, which in this example is acute bronchitis – J20.9.</p> <p>COPD with acute exacerbation codes to J44.1, which “<i>Excludes2</i>” COPD with acute bronchitis and directs the coder to J44.0. A patient may have both conditions at the same time; and when both conditions are documented, both codes may be assigned.</p> <p>Category J44 advises to “code also type of asthma”, if applicable.¹⁰</p>

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