Tips for Improving Clinical Documentation – ICD 10 CM & Beyond

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Agenda

- Documentation Basics
- Risk Adjustment – Why does it matter to you?
- Documentation Changes for ICD 10 CM
  - Family Medicine
  - Pediatrics
  - OB/GYN
  - Cardiovascular
  - Internal Medicine
  - General Medicine
- Questions and Answers

New Conventions in ICD-10 CM

- Excludes1: Mutually exclusive codes indicates that the condition represented by the code and the condition listed as excluded are mutually exclusive and should NOT be coded together.
- Excludes2: The condition excluded is part of the condition represented by the code indicates that the condition excluded is not a part of the condition represented by the code, but the patient may have both conditions at the same time.
- X: A placeholder in codes with less than six characters that require a seventh character extension, the X itself has no meaning and is not replaced with an actual number or letter
- Short Dash: Additional characters should be assigned in place of the - , the additional characters may be letters or numbers.
- With/Without: Within a set of alternative codes, describe options for final character.
- Extensions and Placeholders: Extensions are the seventh character and must appear in that position, regardless of the length of the code.
- Patient seen for the first time Ex. S01.00XA (X) is the placeholder (A) is the seventh character.

General Documentation Tips

General Documentation Criteria

- **Legibility:** The medical record must be legible, a reviewer must be able to read what is written.
- **Visit Date:** The medical record documentation must include the date of the patient visit with month, day and year clearly stated, if notes are multiple pages the date must appear on the lead page.
- **Standard Abbreviations:** Only the use of standard abbreviations is acceptable. The use of symbols is discouraged because they cannot be used for coding purposes.

General Documentation Criteria

- **Use of Symbols:** The use of symbols is acceptable in the Subjective part of the medical record as part of the history, however, the use of symbols is not acceptable in the Assessment/Plan portion of the medical record to describe a medical diagnosis.

- **Signature and Credential:** The progress note must include a clear clinician signature, with a credential after the name, it is important to know which clinician is responsible for the note.

Types of Acceptable Physician (provider) Signatures and credentials

- The credentials for the provider of service must appear in the medical record
  - Next to the provider signature and/or
  - Pre-printed with the provider's name on the group practice stationery
- Hand-written signature or initials, including credentials (*e.g. Mary C. Smith, MD*) are acceptable over a typed name with credential.
- The physician (provider) must authenticate at the end of each note for which services were provided with an:
  - Handwritten signature or
  - Electronic signature
- Electronic signature, including credentials:
  - Requires authentication by the responsible provider (for example, but not limited to, *Approved by, Signed by, Electronically signed by, Authenticated by*
  - Must be password protected and used exclusively by the individual physician (provider).

Signature Logs

- If a medical record contains an illegible signature, providers should include a signature log in their submitted documentation.
- Medicare documentation requirements state each patient encounter should include the date and legible identity of the provider
  - Type or print the provider's name in the first column.
  - Type or print the provider's credential.
  - The physician (provider) should sign his/her legal signature (full name, including credential).
  - Under Actual Chart Signature, the provider should indicate all possible ways that he/she would sign the medical record(initials, first initial/last name, etc).
  - The date of implementation of the Signature Log must be on the Signature Log.

Example: Date of Implementation:_____

Provider Name	Credential	Legal Signature	Actual Chart Signature
John Smith	MD	*John Smith, MD*	*J. Smith, MD*

SOURCE: CMS Medicare Program Integrity Manual (Pub 100-08) Chapter 3, Section 3.3.2.4.B

Improving Documentation

Four keys to improving the quality and usefulness of charted information:

1. **Accuracy**: Good documentation should be legible, free of ambiguous abbreviations, and include details of the patient, date and time for every encounter. If entry is altered, the change should be notated and accompanied by the signature and printed name of the relevant clinician. Double check dictated letters, notes and reports.

2. **Relevance**: Avoid unnecessary comments and vague comments, For example, do not write “no change” – specify the factors related to the patient’s condition that haven’t changed. Do not include inappropriate and irrelevant information, which could result in damaging legal action.

Improving Documentation

3. **Completeness**: The medical record should include all documentation if possible, including all General Practitioner notes, clinic lab results and test results, hospital and specialist notes. Using electronic records can ease compilation and minimize omissions, but intra-and-inter-facility communications is crucial to completeness of documentation.

4. **Timeliness:** A provider must not submit a claim to CMS until the documentation is completed. Until the practitioner completes the documentation for a service, including the signature, the practitioner cannot submit the service to CMS. CMS rules state if the service was not documented then it was not done. Providers should not add late signatures to the medical record beyond the short delay that occurs during the transcription process.

Improving Documentation

- **Timeliness (cont'd**): A provider should never add a signature to a medical record beyond the times discussed above, if a practitioner does not affix a signature at the time of service (also allowing limited delay due to transcription) then the provider may complete an attestation statement. (***IOM Publication 100-08.Chapter 3, Section 3.3.2.5)***
- **Documenting Services:** Practitioners are expected to complete the documentation of services ***"during or as soon as practicable after it is provided in order to maintain an accurate medical record".*** CMS does not provide any specific period, but a reasonable expectation would be no more than 2 days away from the service itself. ***(IOM Publication 100-04, Chapter 12, Section 30.6.1)***

General Documentation/Coding Tips: Unconfirmed Diagnoses

Unconfirmed Diagnoses

- Conditions must be clearly documented to be coded
- Coders should not assume or infer a condition
  - Example: Medical record shows Coumadin as current medication but condition not documented
- For physician/outpatient records do not code conditions that are not definitive

Such as:

- Probable
- Possible
- Questionable
- Suspected
- Rule out
- Differential diagnosis lists

(See Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide, Section 7.2.4)

General Documentation/Coding Tips: *History of*

History of

- *History of* means the patient no longer has this condition
- *History of* conditions often appear in the record's PMH
- Frequent documentation errors regarding use of *History of:*
  - Coding a past condition as active
  - Coding *History of* when condition is still active
- Condition must be active on DOS in order to code

Incorrect Documentation	Correct Documentation
H/O CHF, meds Lasix	Compensated CHF, stable on Lasix
H/O angina, meds Nitroquick	Angina, stable on Nitro
H/O COPD, meds Advair	COPD controlled with Advair

Documentation and Coding: Physicians Role

- Documentation must include at least **one** of the criteria for each diagnosis submitted from the **M.E.A.T.** concept: that the condition was *either*
  - **M**onitored – signs, symptoms, disease progression, disease regression
  - **E**valuated – test results, medication effectiveness, response to treatment
  - **A**ssessed – ordering tests, discussion, review records, counseling
  - **T**reated – medications, therapies, other modalities

- The M.E.A.T. documentation on actively treated conditions must be on the date of service.

Documenting Conditions and Coding to Specificity

- Documenting conditions and submitting complete diagnoses
  - Means coding to the highest level of specificity
  - Following national coding guidelines and
  - Accurately describing a patient's condition through coding nomenclature
- Important items for the medical record
  - Document all of the patient's existing health conditions
  - All chronic conditions must be documented and reported at least once per year
  - Include all required signatures, including credentials and date the progress note

Documentation Changes for ICD 10 CM

Documentation Changes: ICD 10 CM

- **Increased Specificity:**
  - Since there are many new coding options in ICD 10 CM, the codes can capture the specifics that are documented.
  - Document as specifically as possible when documenting the patient's condition.
- Pain:
- When documenting pain, include the following:
  - 1) acuity (e.g. acute or chronic
  - 2) location (right knee behind the patella, LUQ, RUQ)
- Underdosing:
- Underdosing is an important concept and term in ICD 10 CM, it allows identification of when a patient is taking less of a medication than is prescribed.

Documentation Changes
ICD 10 CM

- **Underdosing:**
  - Underdosing is an important concept and term in ICD 10 CM, it allows identification of when a pateint is taking less of a medication than is prescribed.
- When documenting underdosing, include the following:
  - Intentional, unintentional, non compliance, reason? Is the underdosing deliberate (e.g. patient refusal)?
  - Why is the patient not taking the medication? (financial hardship, age-related debility)

ICD 10 code examples:

-

Z91.120	Patient intentional underdosing of medication regimen due to financial hardship
T36.4x6A	Underdosing of tetracyclines, initial encounter
T45.526D	Underdosing of anti-thrombotic, subsequent encounter

Documentation Changes
ICD 10 CM

- **Diabetes**
- When documenting Diabetes, include the following:
  - 1.) Type 1 or Type 2 , due to underlying condition, gestational, drug or chemical induces
  - 2.) Complications – what if any other body system is involved or affected by the diabetic condition (e.g. foot ulcer related to diabetes type 2)
  - 3.) Treatment - is the patient on insulin?
- A number of DM codes are combination codes that include the type of DM, the body system affected and the complications affecting the body system, when missing from documentation these conditions will be harder to code.

Documentation Changes
ICD 10 CM

- **Hyperglycemia and Hypoglycemia**
- It is now possible to document and code for these conditions without using diabetes. You can also specify if the condition is due to a procedure or other cause:

E08.65	**DM due to underlying condition with hyperglycemia**
E09.01	Drug or chemical induced DM with hyperosmolarity with coma
R73.9	Transient post procedural hyperglycemia
R79.9	Hyperglycemia, unspecified

- The final change is the concept of secondary diabetes, it is no longer used in ICD 10 CM, instead these are specific secondary options that can be coded.

Documentation Changes
ICD 10 CM

- **Hypertension**
- In ICD-10, hypertension is defined as essential (primary). The concept of “benign or malignant” as it relates to hypertension no longer exists.
- When documenting hypertension, include the following:
  - **Type** e.g. essential, secondary, etc.
  - **Causal relationship** e.g. Renal, pulmonary, etc.

I10	Essential Hypertension
I11.9	Hypertensive heart disease w/o heart disease
I15.0	Renovascular hypertension

Documentation Changes
ICD 10 CM

- **Injuries**
- ICD-9 used separate “E codes” to record external causes of injury. ICD-10 better incorporates these codes and expands sections on poisonings and toxins.
- When documenting injuries, include the following:
  - **Episode of Care** e.g. Initial, subsequent, sequela
  - **Injury site** Be as specific as possible
  - **Etiology** How was the injury sustained (e.g. sports, motor vehicle crash, pedestrian, slip and fall, environmental exposure, etc.)?
  - **Place of Occurrence** e.g. School, work, etc.
- Initial encounters may also require, where appropriate:
  - **Intent** e.g. Unintentional or accidental, self-harm, etc.
  - **Status** e.g. Civilian, military, etc.

Documentation Changes ICD 10 CM Examples

- **Example 1: A left knee strain injury that occurred on a private recreational playground when a child landed incorrectly from a trampoline:**
- **Injury:** S86.812A, Strain of other muscle(s) and tendon(s) at lower leg level, left leg, initial encounter
- **External cause:** W09.8xxA, Fall on or from other playground equipment, initial encounter
- **Place of occurrence:** Y92.838, Other recreation area as the place of occurrence of the external cause
- **Activity:** Y93.44, Activities involving rhythmic movement, trampoline jumping
- **Example 2: On October 31st, Kelly was seen in the ER for shoulder pain and X-rays indicated there was a fracture of the right clavicle, shaft. She returned three months later with complaints of continuing pain. X-rays indicated a nonunion**.
- The second encounter for the right clavicle fracture is coded as *S42.021K, Displaced fracture of the shaft of right clavicle, subsequent for fracture with nonunion***.**

Let’s code Fractures

39 year old female was carrying groceries into her house when she slipped and fell in the garage, she landed on her right side and on her arm.

Exam: Her right arm was swollen, and it appears to be broken due to its abnormal appearance.

An office x-ray was completed that showed a complete fracture of the shaft of the humerus. Patient was referred to Dr Break, the ortho surgeon on call. Patient was sent to Dr. Break’s office for further evaluation and treatment.

Let’s code,

Review

S42.301A – FRACTURE
W01.0XX**A-** fall from tripping, slipping or stumbling
Y92.015 –single family home, private garage
Y93.01 – Walking, marching or biking as activity
Y99.8 – during leisure activity, activity NEC

When coding fractures, the <u>place of occurrence, activity and status codes</u> should be coded when documented.

When coding **“A” as 7th character (initial encounter),** the activity and status codes should be coded when documented

Documentation Changes
ICD 10 CM

- **Abdominal Pain**
- When documenting abdominal pain, include the following:
  - **Location** e.g. Generalized, Right upper quadrant, periumbilical, etc.
  - **Pain or tenderness type** e.g. Colic, tenderness, rebound

ICD-10 Code Examples

R10.31 Right lower quadrant pain

R10.32 Left lower quadrant pain

R10.33 Periumbilical pain

Documentation Changes
ICD 10 CM – Pediatrics

- **Asthma**
  - ICD-10 terminology used to describe asthma has been updated to reflect the current clinical classification system.
- When documenting asthma, include the following:
  - **Cause** Exercise induced, cough variant, related to smoking, chemical or particulate cause, occupational
  - **Severity** Choose one of the three options below for persistent asthma patients
  - Mild persistent
  - Moderate persistent
  - Severe persistent
  - **Temporal factors** Acute, chronic, intermittent, persistent, status asthmaticus, acute exacerbation

ICD-10 Code Examples

J45.30 Mild persistent asthma, uncomplicated

J45.991 Cough variant asthma

Documentation Changes
ICD 10 CM - Pediatrics

- **Well Child Exams and Screening**
  - ICD-10 will improve the quality of data collection for well child exams, early screening, and the detection of childhood illnesses.
- When documenting well child exams and screen, include the following:
  - **Child's age** In days, months or years as appropriate
  - **Exam type** e.g. Well child exam, hearing screen, sports physical, school physical, etc.
  - **Findings** Note normal vs. abnormal findings, as there codes vary depending on results

ICD-10 Code Examples

Z00.129 Encounter for routine child health examination without abnormal findings
Z00.121 Encounter for routine child health examination with abnormal findings
Z00.110 Newborn check under 8 days old
Z00.111 Newborn check 8 to 28 days old

Documentation Changes
ICD 10 CM – Pediatrics

- **Otitis Media**
- When documenting otitis media, include the following:
  - **Type** e.g., Serous, sanguinous, suppurative, allergic, mucoid
  - **Infectious agent** e.g., Strep, Staph, Scarlett Fever, Influenza, Measles, Mumps
  - **Temporal factors** Acute, subacute, chronic, recurrent
  - **Side** e.g. Left, right or both ears
  - **Tympanic membrane rupture** Note whether this is present
  - **Secondary causes** e.g. Tobacco smoke, etc.

ICD-10 Code Examples

H66.001 Acute suppurative otitis media without spontaneous rupture of ear drum, right ear

H66.004 Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, right ear

H65.03 Acute serous otitis media, bilateral

H72.821 Total perforations of the tympanic membrane, right ear

Documentation Changes
ICD 10 CM – Pediatrics

- **Bronchitis and Bronchiolitis**
- When documenting bronchitis and bronchiolitis, include the following:
  - **Acuity** e.g. Acute, chronic, subacute
    Delineate when both acute and chronic are present, e.g., acute and chronic bronchitis
  - **Causal Organism** e.g. Respiratory syncytial virus, metapneumovirus, unknown, etc.

ICD-10 Code Examples

J20.2	Acute bronchitis due to streptococcus
J21.0	Acute bronchiolitis due to respiratory syncytial virus
J21.1	Acute bronchiolitis due to human metapneumovirus

Documentation Changes
ICD 10 CM – Pediatrics

- **Feeding problems of the newborn**
- In ICD-10-CM, newborn remains defined as the first 28 days of life.
  - Document feeding problems of the newborn and subsequent treatment recommendations specifically in your note.
  - Example issues with discrete ICD-10 coding options include:
    - Difficulty feeding at breast
    - Slow feeding
    - Underfeeding
    - Overfeeding
  - Regurgitation and rumination

ICD-10 Code Examples

P92.1	Regurgitation and rumination of newborn
P92.2	Slow feeding of newborn
P92.5	Neonatal difficulty in feeding at breast

Documentation Changes
ICD 10 CM – OB/GYN

- **Trimester**
- Documentation of trimester is required. Determination is calculated from first day of last menstrual period, and is documented in weeks.
- The definitions of trimesters are:
  - **First trimester** Less than 14 weeks, 0 days
  - **Second trimester** 14 weeks, 0 days through 27 weeks and 6 days
  - **Third trimester** 28 weeks through delivery

ICD-10 Code Examples

O26.851	Spotting complicating pregnancy, first trimester
O26.852	Spotting complicating pregnancy, second trimester
O26.853	Spotting complicating pregnancy, third trimester
O26.859	Spotting complicating pregnancy, unspecified trimester

Documentation Changes
ICD 10 CM – OB/GYN

- **Weeks of Gestation**
  - The majority of codes in Chapter 15 have a final character that indicates the trimester of pregnancy.
  - Additionally, a code from Z3A, Weeks of gestation, should also be reported to identify the specific weeks of the pregnancy.
  - Trimesters are counted from the first day of the last menstrual period.

ICD 10 Code Examples

Z3A.30	30 weeks of gestation of pregnancy
Z3A.40	40 weeks of gestation of pregnancy
Z3A.32	32 weeks of gestation of pregnancy

Documentation Changes
ICD 10 CM – OB/GYN

- **Vomiting**
- The time frame for differentiating early and late vomiting in pregnancy has been changed from 22 to 20 weeks.

ICD-10 Code Examples

O21.0 Mild hyperemesis gravidum

O21.2 Late vomiting of pregnancy

Documentation Changes
ICD 10 CM – OB/GYN

- **Abortion**
- The timeframe for a missed abortion (vs. fetal death) has changed from 22 to 20 weeks.
  - In ICD-10-CM, an elective abortion is now described as an elective termination of pregnancy.
- There are four spontaneous abortion definitions in ICD-10; use the appropriate definition in your documentation:
  - **Missed abortion** No bleeding, os closed
  - **Threatened abortion** Bleeding, os closed
  - **Incomplete abortion** Bleeding, os open, products of conception (POC) are extruding
  - **Complete abortion** Possible bleeding or spotting, os closed, all POC expelled

ICD-10 Code Examples

O02.1	Missed abortion
O36.4XX1	Maternal care for intrauterine death, fetus 1
Z33.2	Encounter for elective termination of pregnancy

Documentation Changes
ICD 10 CM – OB/GYN

- **Childbirth and Puerperium distinct from Trimester**
  - ICD-10 allows for the description of “pregnancy”, “childbirth” and “puerperium” as distinct concepts from “trimester.”

ICD-10 Code Examples

O99.351	Diseases of the nervous system complicating pregnancy, first trimester
O99.352	Diseases of the nervous system complicating the pregnancy, second trimester

Documentation Changes
ICD 10 Cm – OB/GYN

- **Intent of Encounter**
- When documenting intent of encounter, include the following:
  - **Type of encounter** e.g. OB or GYN, contraception management, postpartum care
  - **Complications** Note any abnormal findings with examination

ICD-10 Code Examples

Z30.011	Encounter for initial prescription of contraceptive pills
Z31.82	Encounter for Rh incompatibility status
Z39.1	Encounter for care and examination of lactating mother

Documentation Changes
ICD 10 CM – OB/GYN

- **Complications of Pregnancy**
- Documentation of conditions/complications of pregnancy will need to distinguish between pre-existing conditions, or pregnancy-related conditions.
- When documenting complications of pregnancy, include the following:
  - **Condition detail** Was the condition pre-existing (i.e. present before pregnancy)
  - **Trimester** When did the pregnancy-related condition develop?
  - **Causal relationship** Establish the relationship between the pregnancy and the complication (i.e. preeclampsia)

ICD-10 Code Examples

O99.011 Anemia complicating pregnancy, first trimester

O13.2 Gestational [pregnancy-induced] hypertension without significant proteinuria, second trimester

O24.012 Pre-existing diabetes mellitus, type 1, in pregnancy, second trimester

Documentation Changes
ICD 10 CM – OB/GYN

- **Alcohol use, substance abuse, and tobacco dependence**
  - Documentation should capture the mother's use (or non-use) of tobacco, alcohol and substance abuse along with the associated risk to the child.
  - A secondary code from category F17, nicotine dependence or Z72.0, tobacco use should also be assigned when codes associated with category O99.33, smoking (tobacco) complicating pregnancy are used. In a similar manner, a secondary code from category F10, alcohol related disorders, should also be assigned when codes under category O99.31, Alcohol use complicating pregnancy, are used.

ICD-10 Code Examples

O99.311 Alcohol use complicating pregnancy, first trimester

O99.331 Smoking (tobacco) complicating pregnancy, first trimester

O35.4XX1 Maternal care for (suspected) damage to fetus from alcohol, fetus 1

Documentation Changes
ICD 10 CM – Cardiovascular

- **Acute Myocardial Infarction (AMI)**
- When documenting an AMI, keep the following in mind:
  - **Timeframe** An AMI is now considered “acute” for 4 weeks from the time of the incident, a revised timeframe from the current ICD-9 period of 8 weeks.
  - **Episode of care** ICD-10 does not capture episode of care (e.g. initial, subsequent, sequela).
  - **Subsequent AMI** ICD-10 allows coding of a new MI that occurs during the 4 week “acute period” of the original AMI.

ICD-10 Code Examples

I21.02 ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery

I21.4 Non-ST elevation (NSTEMI) myocardial infarction

I22.1 Subsequent ST elevation (STEMI) myocardial infarction of inferior wall

Documentation Changes
ICD 10 CM – Cardiovascular

- **Congestive Heart Failure**
- The terminology used in ICD-10 exactly matches the types of CHF. If you document “decompensation” or “exacerbation,” the CHF type will be coded as “acute on chronic.”
- When documenting CHF, include the following:
  - **Acuity** e.g. Acute, chronic
  - **Type** e.g. Systolic, diastolic

ICD-10 Code Examples

I50.23 Acute on chronic systolic (congestive) heart failure

I50.33 Acute on chronic diastolic (congestive) heart failure

I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure

Documentation Changes
ICD 10 CM – Cardiovascular

- **Cardiomyopathy**
- When documenting cardiomyopathy, include the following, where appropriate:
  - **Type** e.g. Dilated/congestive, obstructive or nonobstructive hypertrophic, etc.
  - **Location** e.g. Endocarditis, right ventricle, etc.
  - **Cause** e.g. Congenital, alcohol, etc.
    List cardiomyopathy seen in other diseases such as gout, amyloidosis, etc.

ICD-10 Code Examples

I42.0	Dilated cardiomyopathy
I42.1	Obstructive hypertrophic cardiomyopathy
I42.3	Endomyocardial (eosinophilic) disease

Documentation Changes
ICD 10 CM – Cardiovascular

- **Atheroclerotic Heart Disease with Angina Pectoris**
- When documenting atherosclerotic heart disease with angina pectoris, include the following:
  - **Cause** Assumed to be atherosclerosis; notate if there is another cause
  - **Stability** e.g. Stable angina pectoris, unstable angina pectoris
  - **Vessel** Note which artery (if known) is involved and whether the artery is native or autologous
  - **Graft involvement** If appropriate, whether a bypass graft was involved in the angina pectoris diagnosis; also note the original location of the graft and whether it is autologous or biologic

ICD-10 Code Examples

I25.110 Atherosclerotic heart disease of a native coronary artery with unstable angina pectoris

I25.710 Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris

Documentation Changes
ICD 10 CM – Cardiovascular

- **Heart Valve Disease**
- ICD-10 assumes heart valve diseases are rheumatic; if this is not the case, notate otherwise.
- When documenting heart valve disease, include the following:
  - **Cause** e.g. Rheumatic or non-rheumatic
  - **Type** e.g. Prolapse, insufficiency, regurgitation, incompetence, stenosis, etc.
  - **Location** E.g. Mitral valve, aortic valve, etc.

ICD-10 Code Examples

I06.2 Rheumatic aortic stenosis with insufficiency

I34.1 Nonrheumatic mitral (valve) prolapse

Documentation Changes
ICD 10 CM – Cardiovascular

- **Arrythmias/Dysrhythmia**
- When documenting arrhythmias, include the following:
  - **Location** e.g. Atrial, ventricular, supraventricular, etc.
  - **Rhythm name** e.g. Flutter, fibrillation, type 1 atrial flutter, long QT syndrome, sick sinus syndrome, etc.
  - **Acuity** e.g. Acute, chronic, etc.
  - **Cause** e.g., Hyperkalemia, hypertension, alcohol consumption, digoxin, amiodarone, verapamil HCl

- **ICD-10 Code Examples**
- I48.2 Chronic atrial fibrillation
- I49.01 Ventricular fibrillation

Documentation Changes
ICD 10 CM – Orthopedics

- **Fractures**
- When documenting fractures, include the following parameters:
  - **Type** e.g. Open, closed, pathological, neoplastic disease, stress
  - **Pattern** e.g. Comminuted, oblique, segmental, spiral, transverse
  - **Etiology to document in the external cause codes**
  - **Encounter of care** E.g. Initial, subsequent, sequelae
  - **Healing status, if subsequent encounter** e.g. Normal healing, delayed healing, nonunion, malunion
  - **Localization** e.g. Shaft, head, neck, distal, proximal, styloid
  - **Displacement** e.g. Displaced, non displaced
  - **Classification** e.g. Gustilo-Anderson, Salter-Harris
  - **Any complications, whether acute or delayed** e.g. Direct result of trauma sustained
- In addition, depending on the circumstances, it may be necessary to document intra-articular or extra-articular involvement. For certain conditions, the bone may be affected at the proximal or distal end. Though the portion of the bone affected may be at the joint at either end, the site designation will be the bone, not the joint.
- **ICD-10 Code Examples**
- S52.521A Torus fracture of lower end of right radius, initial encounter for closed fracture
- S52.521D Torus fracture of lower end of right radius, subsequent encounter for fracture with routine healing

Documentation Changes
ICD 10 CM – Orthopedics

- **Arthritis**
- In ICD-10-CM, there are specific codes for primary and secondary arthritis. Within the secondary arthritis codes there are specific codes for post-traumatic osteoarthritis and other secondary osteoarthritis. For secondary osteoarthritis of the hip there is also a code for dysplastic osteoarthritis.
- Arthritis codes in ICD-10-CM is both similar and different than ICD-9-CM. For example, currently, in ICD-9, osteoarthritis can be described as degenerative, hypertrophic, or secondary to other factors, and the type as generalized or localized. ICD-10 provides more options for the coding osteoarthritis related encounters, including:
  - Generalized forms of osteoarthritis or arthritis where multiple joints are involved.
  - Localized forms of osteoarthritis with more specificity that includes primary versus secondary types, subtypes, laterality, and joint involvement.
  - Indicate the type, location, and specific bones and joints (multiple sites if applicable) involved in the disease. In addition, describe any related underlying diseases or conditions.

ICD-10 Code Examples

M19.041Primary osteoarthritis right hand

M19.241Secondary osteoarthritis, right hand

M05.432Rheumatoid myopathy with rheumatoid arthritis of left wrist

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- *The information is not intended to take the place of either the written law, regulations, or other industry-sponsored information. We encourage readers to review specific guidelines, regulations, and other interpretive materials for a full and accurate comprehension of their contents*.

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Questions