ICD-10-CM
Specialty Code Set Training
Orthopaedics

2014

Module 4

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Clinical Examples Used in this Book

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are *actual, redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real world* quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.

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Documentation Issues

One of the big hurdles in the transition to ICD-10-CM is ensuring that the documentation of the providers is supportive of the new coding criteria that will need to be met. You may consider that it is not only the codes that are transitioning, but also the documentation to meet it. Just as in ICD-9-CM, ICD-10-CM contains unspecified codes. But, with the greatly expanded granularity in ICD-10-CM, the unspecified codes will come under greater scrutiny.

Specificity

One of the reasons for the transition to ICD-10-CM is the increased specificity to enable conditions to be properly reported. Care must be taken to ensure that providers and coders understand where the code set has expanded to be able to capture that information and denote it on a claim.

Specificity issues include laterality, site, time parameters, underlying cause or nature of the condition, and expansion of certain conditions under ICD-10-CM.

Laterality

The addition of laterality into the code set is one of the reasons for the increased number of codes in ICD-10-CM.

EXAMPLE

ICD-9-CM: 812.21 Fracture of shaft of humerus, closed

ICD-10-CM: S42.301A Unspecified fracture of shaft of humerus, right arm, initial
S42.302A Unspecified fracture of shaft of humerus, right arm, initial
S42.309A Unspecified fracture of shaft of humerus, unspecified arm

When you look at the codes above, there is no reason for the unspecified laterality code to be used.

Unspecified laterality codes assigned due to missing laterality in the documentation have a high probability of being denied. There is no defensible reason not to indicate laterality.

Missing laterality, fracture type, or specific bone site issues may come up in an office using encounter forms, or billing tickets. For instance, the proper documentation may be in the chart note, but a provider may write "distal shaft fracture of humerus" on the form. If the person entering the charges and codes into the computer system does not have access to the medical record, the unspecified code would be the only code that could be assigned.

Consider providers who utilize an EMR and choose their own diagnosis codes. If they have "pick lists" that come up, or type in specific search words for diagnosis, there is a risk that the unspecified codes will populate first. If full descriptors do not show in the EMR fields, the unspecified codes may be chosen by mistake. A thorough check of the EMR and how it looks, how it populates fields, and how providers use it needs to be performed to ensure that the most specific code will be chosen and assigned.

EXAMPLE

A. Patient presents with a fracture of the right humeral shaft. Fracture was reduced and cast placed.

S42.301A Unspecified fracture of shaft of humerus, right arm, initial

B. Patient presents with a oblique fracture of the right humeral shaft. Fracture was reduced and cast placed.

S42.331A Displaced oblique fracture of shaft of humerus, right arm, initial

With the addition of the word "oblique" a specific code is able to be assigned and the unspecified code would not be reported.

Time Parameters

The time parameters acute, chronic, acute on chronic, and recurrent are important documentation factors in ICD-10-CM. The difference between a specified and an unspecified code may be an indication of the time parameter. Documentation should include this factor to assign a code to the highest level of specificity.

EXAMPLE

A. Joy presents for recheck on her gout of her left wrist. She states she has less pain and the joint seems to be more flexible. She says the allopurinol is helping.

M10.032 Idiopathic gout, left wrist

B. Joy presents for a recheck on her chronic gout of her left wrist. She states she has less pain and the joint seems to be more flexible. She says the allopurinol is helping.

M1A.032 Idiopathic chronic gout, left wrist

With the addition of the word "chronic" a more specific code is able to be assigned.

Site

There are additional codes in ICD-10-CM due to site specificity. Fracture coding is a good example of the expansion of site in the code set. Documentation must meet these new criteria to avoid unspecified code usage when possible.

EXAMPLE

A. Jon is brought in by his mother for a recheck of his radial torus fracture of the right arm. Everything is healing well after two weeks. Mom will bring him back next week for possible cast removal.

S52.91XD Unspecified fracture of right forearm, subsequent encounter with routine healing

B. Jon is brought in by his mother for a recheck of his distal radial torus fracture of the right arm. Everything is healing well after two weeks. Mom will bring him back next week for possible cast removal.

S52.521D Torus fracture of lower end of right radius, subsequent encounter with routine healing

Notice in example A, without the documentation about the specific site on the radius, the type of fracture is also not able to be coded. That is one of the dangers of incomplete documentation. Other pieces of important information may be left out of the code verbiage when an unspecified code is used.

Other and Multiple Issues

In some cases, multiple issues previously discussed will be present (underlying condition, site, laterality). Othopedists need full education on these areas to ensure that unspecified codes will not be used, or multiple inquiries may need to be made to the provider in order to receive enough information to assign the correct code.

EXAMPLE

A. 78-year-old Patricia comes to the office complaining of pain in her wrist. She states she fell yesterday evening. She caught herself on both hands, but immediately had pain in her wrist. Plain films where obtained.

Diagnosis: Distal fracture of radius

S52.509A Unspecified fracture of the lower end of unspecified radius, initial encounter

W19.XXXA Unspecified fall, initial encounter

B. 78-year-old Patricia comes to the office complaining of pain in her left wrist. She states she slipped while getting up from her chair and fell. She caught herself on both hands, but immediately had pain in her wrist. Plain films where obtained. Past medical history is positive for osteoporosis and hypertension. This is her first osteoporotic fracture.

Diagnosis: Osteoporotic fracture of left distal radius

M80.032A Age-related osteoporosis with current pathological fracture, left forearm, initial encounter

W07.XXXA Fall from chair, initial encounter

In example B, the notation of the underlying condition of osteoporosis identifies this as a pathologic fracture. Laterality is also indicated. With the additional information given regarding the fall, it clearly identifies the trauma as minor that would not normally result in a fracture. The addition of this information allows for much more specific codes to be assigned.

Documentation Requirements for Common Conditions in Orthopaedics

To assist the providers with clinical documentation improvement, it is necessary that the coder/auditor/educator understand the documentation requirements of the most commonly coded conditions in their specialty. Listed below are the documentation requirements for some of the common conditions seen in an orthopaedic practice.

Fractures

For correct coding of fractures, documentation should include the following:

- Contributing factors
  - Trauma
  - Pathological
  - Stress/fatigue
  - During placement of device, implant, graft
- Type
  - Greenstick
  - Bent bone
  - Spiral
  - Comminuted
  - Segmental
  - Transverse
  - Compression
  - Monteggia's
  - Galezzi's
  - Torus
  - Oblique
  - Colle's
  - Smith's
  - Barton's
  - Bimalleolar
  - Trimalleolar
  - Maisonneuve's
  - Pilon
  - Salter-Harris type
  - Open
    - » Degree of soft tissue involvement
    - » Degree of contamination
  - Bone alignment
- Underlying condition
  - Osteoporosis
  - Neoplasm
  - Osteomyelitis
  - Osteolysis
  - Osteonecrosis
  - Paget's disease
  - Osteomalacia

    - Osteogenesis imperfect
    - Cysts
- Anatomy
- Site (of bone)
    - Distal
    - Proximal
    - Shaft
    - Surgical neck
    - Greater tuberosity
    - Lesser tuberosity
    - Supracondylar
    - Intercondylar
    - Epicondylar
    - Medial condylar
    - Transcondylar
- Complications
    - Malunion
    - Nonunion
    - Delayed healing
- Localization/Laterality

EXAMPLE

A 35-year-old presented to the emergency department with a painful, right wrist. Upon examination the wrist is swollen and there is pain with palpation of the wrist area with limited grip strength of the right hand. Pain is noted to be in the anatomic snuffbox and upon extension a radial deviation is noted. A mid third scaphoid fracture is confirmed by plain film. Fracture is reduced in office and patient is placed in a long arm cast.

S62.021A Displaced fracture of middle third of navicular [scaphoid] bone of right wrist, initial encounter

Osteoporosis

For correct coding for osteoporosis, documentation should include the following:

- Type
    - Age-related
    - Primary
    - Secondary
    - Postmenopausal
    - Drug-induced
    - Idiopathic
    - Postoophorectomy

- Postsurgical malabsorption
- Post-traumatic

- Complication/manifestations
  - Fracture
    - Anatomy
    - Laterality
  - Major osseous defect
- Contributing factors
  - Drug (if drug induced)
- Temporal factors
  - History of previous fractures

EXAMPLE

Sarah is a 84-year-old Caucasian woman who presents to the emergency department for pain in her arm. While cleaning her home she bumped her right shoulder into a door frame. She states she did not bump it very hard but expects she will have a bruise in the morning. She is complaining of pain in her shoulder and upper arm and is unable to lift her arm. X-ray of the shoulder confirms a 2 part fracture of the surgical neck of humerus. Bone density scan confirms osteoporosis.

M80.021A Age-related osteoporosis with current pathological fracture, right humerus, initial encounter

Osteoarthritis

For correct coding for osteoarthritis, documentation should include the following:

- Type
  - Polyosteoarthritis
  - Primary
  - Secondary
  - Erosive
- Contributing factors
  - Trauma
  - Hip dysplasia
- Symptoms/Findings/Manifestations
  - Heberden's nodes
  - Bouchard's nodes
- Localization/Laterality
- Anatomy

EXAMPLE

Subjective: 66-yr-old with a history of slowly progressive pain in the left knee. She has noted some enlargement of the knee and considerable crepitance on motion. There has been no significant warmth or redness and symptoms appear confined to that knee. She has difficulty getting out of a chair and can only walk for two blocks with a cane. She cannot recall any history of trauma to the knee.

Objective: Exam reveals range of motion limited between 15 and 90 degrees. There is severe crepitance on motion and palpable osteophytes. Minimal effusion is noted. There is moderate genu varus on standing. X-rays demonstrate marked joint space loss particularly in the medial compartment with prominent diffuse osteophytes.

Assessment: Primary osteoarthritis confined to the left knee

M17.12 Unilateral primary osteoarthritis, left knee

Gout

For correct coding for gout, documentation should include the following:

- Temporal factors
  - Chronic
  - Acute
- Type
  - Idiopathic
  - Lead-induced
  - Drug-induced
  - Due to renal impairment
- Association
  - Toxic effects of lead or lead compounds
  - Drug
  - Renal disease
  - Underlying condition
- Manifestations
  - Gout tophi
  - Autonomic neuropathy
  - Calculus of urinary tract
  - Cardiomyopathy
  - Disorders of external ear
  - Disorders of iris and ciliary body
  - Glomerular disorders
- Localization/Laterality
- Anatomy

EXAMPLE

A 53-year-old man presents complaining of severe pain and swelling of his left elbow. He is concerned that it is infected due to its appearance. The pain started yesterday. He denies fever, chills, nausea, HA, and injury to the area. Medical history includes hypertension, hyperlipidema, and obesity. He drinks 10 to 12 beers per week. States he was at a birthday party yesterday and "may have had too many."

Exam: Temp 100.8 Elbow is swollen, warm, red and very tender. BMI 32.5, patient does not follow any regular diet. Remainder of the exam is normal. Synovial fluid was obtained and revealed rod shaped crystals. Labs are positive for elevated uric acid levels and combined hyperlipidemia.

Assessment: Gouty arthritis precipitated by alcohol use and obesity

M10.022 Idiopathic gout, left elbow

E66.09 Other obesity due to excess calories

E78.2 Mixed hyperlipidemia

Z68.32 Body mass index [BMI] 32.0–32.9, adult

F10.99 Alcohol use, unspecified with unspecified alcohol-induced disorder

Osteomyelitis

For correct coding of osteomyelitis, documentation should include:

- Temporal factors
  - Acute
  - Subacute
  - Chronic
- Type
  - Haematogenous
  - Multifocal
  - Brodie's abscess
- Contributing factors
  - Infectious agent
- Manifestations
  - Major osseous defect
- Anatomy
- Laterality

EXAMPLE

An 8-year-old white male presents with infected appearing area of right ankle a two weeks ago. Mother states she has been cleaning the area and applying Neosporin, but the area has been getting larger and more painful. Now his ankle and part of his foot are swollen and red and it hurts to walk on it.

Exam: Patient does not appear acutely ill. Temp 99.2. Ankle shows subsiding infection. Ankle is swollen with erythema. ROM is limited secondary to pain. X-ray show soft tissue swelling and obliteration of tissue planes and periosteal elevation of the distal fibula. Labs showed elevated WBC, culture positive for streptococcus pneumonia.

Assessment: Acute osteomyelitis due to bacterial infection.

M86.061 Acute hematogenous osteomyelitis, right tibia and fibula

B95.3 Streptococcus pneumonia as the cause of disease classified elsewhere

Assisting Providers with Transition to ICD-10-CM

A real emphasis needs to be made with all providers to move away from usage of unspecified codes. As seen in the many examples given previously, a few more precise words and sentences can allow for more specific code assignment. There is a high risk for denial by payers under ICD-10-CM for certain unspecified code usage.

Multiple assessments may need to be made in a practice to ensure that documentation meets the standards of ICD-10-CM. If a practice utilizes diagnosis-driven templates, whether electronic or paper, an assessment will need to be performed to ascertain if changes need to be made to the templates to meet ICD-10-CM specificity. For example, fracture templates will need to include site, laterality, type, and status of healing in the template for complete documentation for the best code selection. If updates are necessary, the providers need to be made aware of all the changes with time enough to get used to them.

The best way to help providers transition their documentation to be ICD-10 ready is to perform documentation readiness assessments. If the providers don't know how the coding parameters have changed for ICD-10-CM, they cannot be expected to meet them. A documentation assessment will compare the documentation of the provider today against ICD-10-CM to show the providers the differences. This will allow time to prepare and make any documentation adjustments necessary.

The first step to performing an ICD-10-CM documentation readiness assessment is to generate a frequency report based on diagnosis codes that have previously been reported for the entire practice. The frequency report can also be generated for a clinic to compare top codes by facility. Finally, run a frequency report based on individual providers. With the entire practice report, you will be able to see a couple of things: 1) Which codes are most used and 2) if they are unspecified codes. Compare these codes to their ICD-10-CM counterparts to assess how much, if any, they will change. This will give you a "big picture" of what the practice will need to do to become ICD-10 documentation ready. If you have multiple clinics, the report will give you an idea of which clinic will need the most help, education, and time to make the documentation upgrade for ICD-10-CM.

The report you run by provider will be your working list for education. Take the number one code for the provider. Run another report looking for patients with that diagnosis in the past 1-2 months. From that report, pull the charts for 10-15 patients with these diagnoses. From the documentation

present, can you assign an ICD-10-CM code? If so, are they codes that are comprehensive, or are they unspecified codes? Next, create a report by patient that shows what, if any ICD-10-CM code could be assigned and what deficiencies, if any, were present that made the record unable to support a more specific code. If there were no deficiencies, point that out also.

After the report is put together, take a copy of the chart notes and the report and meet with the provider. Show the provider where the deficiencies are in their documentation as it relates to ICD-10-CM. Show them what needs to be present to assign an ICD-10-CM code to the highest level of specificity. There should be a Quality Assurance (QA) percentage that your providers are expected to meet from a compliance standpoint. If they did not meet QA, then the same condition will be assessed at their next session. The same condition will continue to be assessed with education provided until QA is met for that condition. Once met, the next diagnosis on the list is assessed and the process is repeated. This tool is very important as it relates to the most used diagnoses for each provider, using their own recent notes, showing them how their documentation directly relates to a code.

EXAMPLE

Physician Name: Robert Smith, M.D.			**Date of Assessment:** mm/dd/yyyy
Review/Auditor: Mary Clark, CPC,CPMA			
Chart	**Patient ID**	**ICD-10-CM code(s)**	**ICD-10-CM code description**
1	A24499	S43.005A	Unspecified dislocation of left shoulder joint, initial encounter

In ICD-10-CM, to assign a code for dislocation of the shoulder to the highest level of specificity, documentation must include if the dislocation was partial or complete, bone dislocated, and position of dislocation.

Chart	**Patient ID**	**ICD-10-CM code(s)**	**ICD-10-CM code description**
2	M242490	M20.11	Hallux valgus (acquired), right foot

Code appears to make transition to ICD-10-CM.

Chart	**Patient ID**	**ICD-10-CM code(s)**	**ICD-10-CM code description**
3	J25092	M48.40XD	Fatigue fracture of vertebra, site unspecified, subsequent encounter routine healing

In ICD-10-CM, to assign a code for vertebral stress fracture to the highest level of specificity, documentation must include the site of the vertebral fracture(s).