ICD-10 Documentation for Orthopedics
Objectives

At the completion of this lesson the learner will be able to:

• Identify frequently utilized orthopedics diagnoses and procedures
• Identify the ICD-10 changes associated with frequently utilized orthopedics diagnoses and procedures
• Define documentation recommendations for each diagnosis and procedure
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Important Considerations for Orthopedic Documentation include:

- Document location with specificity and laterality
- Document encounter to reflect initial treatment, subsequent encounters, or sequela
- Document the clinical findings/indicators to support the diagnosis documented
- Open bone fractures will now require additional information related to Gustilo-Anderson Classification of severity
- Understand procedure code Axes and ensure documentation is present to support specificity
- Recognize limited availability of “Not Otherwise Specified” options with many orthopedic procedures → Attention to detail will prevent future queries due to inability to complete a procedure code
- Document related, secondary or causal illness whenever appropriate
- Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, or are documenting an uncommon diagnosis, or infrequently performed procedure
Section 1: ICD-10 Diagnostic Documentation Recommendations

ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Orthopedics Documentation for ICD-10

The dramatic increase of codes for orthopedic diagnosis will allow for:

- Greater specificity in orthopedic diagnosis codes
- Coder ability to capture documentation detail

**50% (34,250)** of all ICD-10-CM codes are related to the musculoskeletal system

**25% (17,045)** of all ICD-10-CM codes are related to fractures

**63% (10,582)** of fracture codes distinguish laterality
Most Common Orthopedic Diagnoses

This module is focused on the most frequently documented diagnoses that will have the greatest impact on the provider including:

- Bone Fracture
- Diseases of the Bone
- Diseases of the Soft Tissue
- Joint Disease
- Complications Healing

Note: This training module is not intended to be an all-inclusive training tool to teach the provider every coding nuance within ICD-10
Documenting Complications

Complications with a procedure or a device requires the same specificity of documentation regardless of the initial cause or patient presentation:

1. Clearly defining the complication either of procedure or device
2. Identifying the complication as causal to the patient presentation
3. Clearly identifying if this was an expected or unexpected outcome
Bone Fractures

Review of bone fracture documentation is divided into two parts:

1. Pathologic Bone Fracture
2. Traumatic Bone Fracture

Important ICD-10 Changes for Fractures include:

• Largest single group of additional codes
• Require providers to address type, laterality, site and encounter
Bone Fracture

Documentation of Encounter Type:

- **Initial**—are for a new injury that is receiving active treatment directed at the injury
  - These visits include surgical treatment, ED encounter, and evaluation/treatment by a new physician.
- **Subsequent**—occur during the healing and recovery phase
  - These visits include cast changes, removal of external or internal fixation devices, medication adjustments, and other aftercare/follow-up visits following initial treatment of the injury
- **Sequela**—occur as a direct result of an injury
  - List the initial injury that required medical care

Examples:

- Displaced comminuted fracture of shaft of ulna of the right arm subsequent encounter for delayed healing
- Osteoporosis with pathologic fracture of the right forearm, initial encounter
- Stress fracture of the right hand, initial encounter
Pathologic Bone Fractures

Documenting Pathologic Fractures:
• Make a connection between the causal factor and the fracture
• Document the location of the fracture with specificity
• Encounter documentation is consistent for all fracture types

Examples:
Age-related osteoporosis with current pathological fracture of right femur
Pathological fracture in neoplastic disease of left ankle
Documentation of Traumatic Fractures:

- The coder is required to assume the least traumatic injury unless otherwise specified—
  - Nondisplaced vs. Displaced
  - Closed vs. Open

- Document information regarding the activity, location and circumstance surrounding the injury.
  - MVC, Tractor accident, Fall, GSW

- Specificity increases with traumatic bone injury—
  - Calcaneus—body, tuberosity, extraarticular

- Specify other injuries related to the fracture e.g. tendons, nerves, arteries, etc.
# Gustilo-Anderson Classification for Open Fractures

The Gustilo-Anderson Classification system separates open fractures based upon: **size of wound**, **soft tissue injury** and **contamination**

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<th>Description</th>
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<td>I</td>
<td>Open fracture, clean wound, wound &lt;1 cm in length</td>
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<tr>
<td>II</td>
<td>Open fracture, wound &gt; 1 cm in length without extensive soft tissue damage, flaps, avulsions</td>
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<tr>
<td>III</td>
<td>Open fracture with extensive soft-tissue laceration, damage, or loss or an open segmental fracture. This type also includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for 8 hr prior to treatment</td>
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<tr>
<td>IIIA</td>
<td>Type III fracture with adequate periosteal coverage of the fracture bone despite the extensive soft-tissue laceration or damage</td>
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<tr>
<td>IIIB</td>
<td>Type III fracture with extensive soft-tissue loss and periosteal stripping and bone damage. Usually associated with massive contamination. Will often need further soft-tissue coverage procedure (i.e. free or rotational flap)</td>
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<tr>
<td>IIIC</td>
<td>Type III fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury.</td>
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Intervertebral Disc Disorder

Documentation for Intervertebral Disc Disorder should include the following Components:

• Document site (cervical thoracic, lumbar, etc.)
• Document if associated with Myelopathy, Radiculopathy or sciatica
Osteoarthritis

Osteoarthritis documentation should contain these components:

- Document type e.g. primary generalized, secondary, posttraumatic, or other type
- Document site and laterality

Examples:

- *Posttraumatic osteoarthritis of the left knee*
- *Primary generalized osteoarthritis of the spine*
Other Conditions

Osteoporosis

• Age-related or other causes (if drug-induced, identify as an adverse effect)
• If localized and location
• Presence or absence of fracture

Osteomyelitis

• Identify Acute, Subacute, or Chronic
• Identify the infectious agent and any other major osseous defects
• Site and Laterality specific
• Presence of Draining Sinus

Examples:

Acute hematogenous osteomyelitis, right femur

Age-related osteoporosis without fracture

Chronic osteomyelitis with draining sinus of right tibia and fibula
Diagnoses of the Muscle and Connective Tissue

Important changes in documentation of this type are primarily related to:

- **Specificity of Location** (muscle of the upper right arm, flexor tendons, extensor tendons)
- **Laterality** (right, left, bilateral)
- **Cause** (traumatic vs. non-traumatic, “use, overuse, and pressure”)

Examples:
- *Prepatellar bursitis, right knee*
- *Ganglion, right ankle, right foot*
- *Traumatic separation of muscle, right lower leg*
Joint Diagnoses

Arthritis
- Cause (primary, staphylococcal, pneumococcal, streptococcal, rheumatoid, juvenile)
- Location (bilateral, right knee, left shoulder, vertebrae)

Gout
- Cause (idiopathic, drug-induced, secondary to renal impairment or other causes)
- Episode (chronic, acute, attack, flare)
- Location (ankle, right foot, left hand, right elbow)
- Detail the mindset (intentional, unintentional, assault, undetermined)
- Indicate the presence or absent of tophi

Examples:
*Pneumococcal arthritis, right hand*
*Rheumatoid arthritis with rheumatoid factor of right wrist without other organ or system involvement*
*Chronic gout due to renal impairment left knee*

*Rheumatoid diagnosis should also include present of rheumatoid factor and documentation of other organ or system involvement*
Section 2: ICD-10 Procedure Documentation Recommendations

ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
ICD-10 Procedure documentation: More granular and precise

Focus for Providers: Understand concepts related to coding capture rather than memorize every detail

• Procedure documentation can be thought of on multiple axes
• Each axis captures an increased amount of provider documentation in respect to the service or procedure performed
Axis 1: Starting point for coding procedures

Provides the coder with the initial criteria to class information and narrows available codes

Orthopedic procedures are located in highlighted sections. Examples include:
Medical and Surgical
Placement
Measurement and Monitoring

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Axis 2: Body System

As the axis increases so does the specificity of Documentation AND Coding.

Depending on the section identified the axis may be:

- Body System
- Physiologic System
- Anatomic Region

Ortho Examples of Axis 2:

- Muscles
- Tendons
- Bursae and Ligaments
- Head and Facial Bones
- Upper/Lower Bones
- Upper/Lower Joints
- Upper/Lower Extremities
Axis 3: Root Operation

Root Operation determines the purpose of a procedure. There are 31 specific types of root operations that are in 9 groups:

1. Procedures that take out some or all of a **body part**
2. Procedures that take out **solids/fluids/gases** from a body part
3. Procedures involving **cutting or separating** only
4. Procedures that **put in/put back** or **move** some/all of a body part
5. Procedures that **alter the diameter/route of a tubular body part** – can be performed only on tubular body parts
6. Procedures that always **involve a device**
7. Procedures involving **examination** only
8. Procedures that **define other repairs**
9. Procedures that **define other objectives**
Axis 3: Root Operation

Orthopedic Examples of Axis 3-Root Operation:

- Detachment—BKA, disarticulation of right shoulder
- Reattachment—Reattachment of foot
- Inspection—diagnostic arthroscopy
- Replacement—total hip, total knee
- Reposition—ORIF left femur

Documenting for Axis 3:

- Don’t attempt to memorize the coding verbiage for each root operation
- Ensure that documentation of each procedure has a clear objective/purpose
- Ensure that one of the 9 groupings of operations can be identified
Axis 4: Body Part

Axis 4: Very specific and detailed

The type of procedure dictates the specificity of documentation:

- A body part
- Some of a body part
- Area around a body part
- In or On a body Part
- Conduction mechanism (brain or heart)

Orthopedic Examples of Axis 4:

- Hand
- Right Hand
- Thumb
- Proximal phalanx of right thumb
- Distal phalanx of right thumb

Increasing Specificity
Axis 5: Approach

**Axis 5:** Defined based on access location, method and types of instrumentation used:

- **Open**—Cutting through skin or mucous membrane and other body layers necessary to expose procedure site
- **Percutaneous**—Entry, by puncture or incision, of instrumentation through skin or mucous membrane and other body layers necessary to reach procedure site
- **Percutaneous endoscopic**—Entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and other body layers necessary to reach and visualize procedure site
- **Via natural or artificial opening**—Entry of instrumentation through natural or artificial external opening to reach procedure site
- **Via natural or artificial opening endoscopic**—Entry of instrumentation through natural or artificial external opening to reach and visualize procedure site
- **Open with percutaneous endoscopic assistance**—Cutting through skin or mucous membrane and other body layers necessary to expose procedure site, and entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and other body layers necessary to aid in performance of the procedure.
- **External**—Procedures performed directly on skin or mucous membrane and procedures performed indirectly by application of external force through skin or mucous membrane
Axis 6: Device

Devices left in place at the completion of a procedure are coded

Examples include:
- Non-Autologous Tissue
- Autologous Tissue
- Synthetic Substitutes
- Drainage Devices
- Joint Prosthesis
- Orthopedic Pin

Devices in the “Placement” Section:
- Most Surgical Procedures contained in the Medical Surgical Sections of Coding
- Non-surgical ortho procedures often found in the Placement section
- Devices in this section include:
  - Cast
  - Splint
  - Bandage
Axis 7: Qualifier

Axis 7 defines the “qualifier” or an additional attribute of the procedure, when appropriate

- Not all procedures will have qualifiers
- Data adds specific, clarifying information that is not contained in another axis

**Examples of Orthopedic Procedure Qualifiers:**
- Fixator Types: monoplanar, ring or hybrid
- Joint Replacement Device: cemented vs. uncemented
Frequent Musculoskeletal Procedure Examples

Documenting for Musculoskeletal System and Connective Tissue

Spinal Fusion

• Spinal level; single, multiple vertebral joints
• Document the approach e.g. anterior, posterior, etc.
• Device used
• Materials used on the vertebral joint to render the joint immobile
Excision of Intervertebral Disc:

- Specify site
- Differentiate between removal of a *portion* or *all* of an Intervertebral disc
- Document approach e.g. open, percutaneous, etc.

Bone Biopsy (Excision):

- Document location and if excision
- Document site Laterality
- Document approach e.g. open, percutaneous
Course Conclusion

While the actual number of orthopedic diagnoses and procedure codes has increased from ICD-9 to ICD-10, the structure and function of coding has improved to better represent the diagnosis and acuity of orthopedic patients.

While this training is not inclusive of every diagnosis and procedure, the themes across orthopedic documentation include:

- Recall the procedure code Axes and ensure documentation is present to support specificity
- Recognize limited availability of “Not Otherwise Specified” options with many orthopedic procedures, attention to detail will prevent future queries due to inability to complete a procedure code
- Document location with specificity and laterality
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