

## ICD-10 ORTHOPEDIC and PHYSICAL THERAPY

Payers and Providers Partnering for Success

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# DOCUMENTATION and CODING CONCEPTS



### **CLINICAL DOCUMENTATION IMPACTS**

- With ICD-10-CM you must re-document or reference extensive details surrounding the circumstances of injury to ensure correct coding and proper claims processing.
- Identifying the affected side is important, as some payers will not reimburse claims with "unspecified" codes.
- Correctly coding the fracture ensures the provider will be reimbursed for appropriate followup visits and that the patient can receive appropriate outpatient (i.e., PT, imaging, etc.) services.
- The circumstances of injury such as where and how it occurred are important for claims processing and coordination of benefits.

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### **DOCUMENTATION CRITERIA – PHYSICIAN AND STAFF**

- The physician, must take time to learn how to code; you should not solely rely on delegating the task to others.
- Work that is done must be justified by the patient's diagnoses.
- Orthopedic surgeons typically document three elements of the HPI in a single sentence: "Mary Smith comes in today; she has a 3-month history of moderate pain in the right knee." Such documentation is not time-consuming.
- Do not refer to diagnoses from a prior progress note, etc...
- When diagnosing a patient's condition make sure you evaluate each condition and not just list it, for example:
  - Left Chopart joint sprain-Continue with ice and boot for weight bearing activities
  - **Right ankle sprain**-Motrin 800 mg t.i.d, Tylenol 1 gm q.i.d. as needed, Walking cast is prescribed.



### **DOCUMENTATION CRITERIA – PHYSICIAN AND STAFF**

- All progress notes **must** be signed by the provider rendering the services and included with signature should be the providers credentials (stamped signatures are no longer acceptable since 1/2009).
- EMR notes must have the following wording as part of the signature and note must be closed to all changes:
  - Electronically signed
  - Authenticated by
  - Signed by
  - Validated by
  - Approved by
  - Sealed by
- Any changes that are to be made to a closed encounter can be added as a separate addendum to the DOS, but must be done in a timely manner.



### **DOCUMENTATION CHANGES**

- 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.
- With the increased number and specificity of codes under ICD-10, physicians are going to have to be more specific in their patient encounter documentation to provide the coders the best opportunity to choose the most correct codes for the most appropriate reimbursement.
- For orthopedics the focus is on increased specificity. Over 1/3 of the expansion of ICD-10 codes is due to the addition of laterality (left, right, or bilateral).
- Physicians and other clinicians likely already note laterality when evaluating the clinically pertinent anatomical site(s).
- Physicians will be judged on documentation more critically in ICD-10.



### **PT/OT/ST DOCUMENTATION**

- ICD-10-CM does not provide a separate diagnosis code.
- Therapy documentation must indicate the reason for the treatment and describe the reason.
- For PT and OT be sure to include the body part evaluated, all conditions and complexities that may impact treatment.
- The treatment diagnosis may or may not be identified by the therapist depending on the scope of their practice.
- Where a diagnosis is not allowed, use a condition description similar to the appropriate code, example:
  - Medical diagnosis made by physician is CVA, however the treatment diagnosis or condition description for PT may be abnormality of gait and for OT may be hemiparesis and for ST could dysphagia.







### **CHANGES FROM ICD-9 TO ICD-10**

- ICD-10-CM codes specify laterality.
- In ICD-9-CM, coders use V codes and E codes.
- The current V codes will become Z codes in ICD-10-CM.
- The E codes used in ICD-9-CM will fall within the S00-Y99.9 codes in ICD-10-CM.
- ICD-10-CM now captures the side and specific bone or joint.



### **ICD-10 STRUCTURE & CONTENT**

- ICD-10 diagnosis codes have between 3 and 7 characters
- Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of any or all of the 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> characters.
- Digits 4-6 provide greater detail of etiology, anatomical site and severity.
- A code using only the first three digits is to be used only if it is not further subdivided.



M80.051A- Age-related osteoporosis with current pathological fracture, right femur, initial encounter for fracture



### **VARYING CHANGES BY CLINICAL AREAS**

Clinical Area	ICD-9 Code	ICD-10 Codes
Fractures	747	17099
Poisoning and Toxic effects	244	4662
Pregnancy related conditions	1104	2155
Brain Injury	292	574
Diabetes	69	239
Migraine	40	44
Bleeding disorders	26	29
Mood related disorders	78	71
Hypertensive Disease	33	14
End stage renal disease	11	5
Chronic respiratory failure	7	4

**Note:** Approximately 25,000 of the estimated 69,000 ICD-10-CM codes refer to laterality (left/right)

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### **ORTHOPEDIC ICD-10 BILLING AND CODING**

- The orthopedic section of codes is expanding more than any other section of the new code sets.
- If you are a provider, then you will need to understand how ICD-10 requires specific documentation documentation that differs from what was sufficient for ICD-9.
- If you are a coder, you must know how to translate the clinical information from the operative report into the ICD-10 system. One incorrect character and your entire claim will be undermined.
- Orthopedic providers and coders, in particular, will have a difficult transition. For example, when ICD-9 becomes ICD-10, your fracture codes explode with ultra specific options, meaning providers have to document extensive details to ensure the right diagnosis.
- Orthopedic practices may have a more challenging time with ICD-10 when it comes to Medicare as treatment for many Medicare patients often includes the use of durable medical equipment (DME), in addition to physician services.



### **ORTHOPEDIC ICD-10 BILLING AND CODING**

- This equipment is billed differently than physician services. Therefore, orthopedic offices and staff will need to submit ICD-10 codes for both Medicare Part A and Part B claims.
- If you are not ready to use ICD-10 codes by the deadline, claims and other transactions will be rejected and will need to be resubmitted with ICD-10 codes, thus affecting reimbursements and cash flow.

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• Be prepared to see a decrease in productivity and accuracy, as well as the need for additional training and education.



### PT/OT/ST ICD-10 CODING

- Codes applicable to rehab therapist can be found in Chapter 19: Injury, poisoning and certain other consequences of external causes as well as Chapter 13: Diseases of the musculoskeletal system and connective tissue.
- Generally for injuries you should code chronic or recurrent using codes from Chapter 13 but for current, acute injuries you would code using the appropriate injury code from Chapter 19.
- All V57 codes will map to the same one code in ICD-10-CM, Z51.89 so those who use V57 in ICD-9-CM now will in ICD-10-CM use Z51.89.

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- There is an instructional note using Z51.89 stating "code also condition requiring care."
- The aftercare Z codes should not be used for aftercare for injuries



# DOCUMENTATION REQUIREMENTS

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### **DOCUMENTING INJURIES**

- Orthopedic injuries tend to come in two basic types:
  - Acute
    - Acute injuries are those that involve sudden trauma, these include sprains, strains, bruises, and fractures.
  - Overuse
    - Overuse injuries result from using a part of the body too much, causing a series of repeated small injuries.

- When documenting injuries, include the following:
  - **Episode of Care** e.g. Initial, subsequent, sequelae
  - 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.



### **INJURIES**

- Laterality for all conditions that affect limbs.
- Encounter type as initial, subsequent and sequela.
- Gustilo classification type for open fractures.
- Malunion and nonunion for each fracture site and type.
- Injuries are grouped by body part rather than category of injury.
- Aftercare "Z" codes should not be used for aftercare of injuries/fractures where seventh characters are provided to identify subsequent care

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### ACUTE TRAUMATIC VERSUS CHRONIC OR RECURRENT MUSCULOSKELETAL CONDITIONS

- Many musculoskeletal conditions are a result of previous bone injury or trauma to a site, or are recurrent conditions.
- Bone, joint or muscle conditions that are the result of a healed injury are usually found in chapter 13 as well as any recurrent bone, joint or muscle conditions.
- Any current, active injury should be coded to the appropriate injury code from chapter 19.
- If it is difficult to determine from the documentation in the record which code is best to describe a condition, query the provider.



### **DOCUMENTING FRACTURES**

- When documenting fractures, include the following parameters:
  - **Type** e.g. Open, closed, pathological, neoplastic disease, stress (if not designated as open or closed then closed should be coded)
  - 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 (if not noted as displaced or nondisplaced then it should be coded to 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 intraarticular 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.



### **ARTHROPATHIES AND POLYARTHROPATHIES**

• Identify the anatomical site(s) affected and the laterality for each site with as much detail as possible.

- Choices for the anatomical site(s) include
  - Shoulder
  - Elbow
  - Wrist
  - Hand
  - Hip
  - Knee
  - Ankle and foot
  - Vertebrae
  - Multiple joints
- Describe any underlying disease or condition present.



### **RHEUMATOID ARTHRITIS**

- Identify the anatomical site(s) affected and the laterality for each site.
- State if condition is with or without rheumatoid factor.
- Note further specifications are possible and include:
  - Felty's syndrome
  - Rheumatoid lung disease with rheumatoid arthritis
  - Rheumatoid vasculitis with rheumatoid arthritis
  - Rheumatoid heart disease with rheumatoid arthritis
  - Rheumatoid myopathy with rheumatoid arthritis
  - Rheumatoid polyneuropathy with rheumatoid arthritis
  - Rheumatoid arthritis with involvement of other organs and systems
  - Rheumatoid arthritis without involvement of other organs or systems

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### PAIN

- State the acuity (i.e., acute or chronic).
- Identify the cause (e.g., trauma).
- Detail the following when patients are admitted for pain management or control
  - Psychological pain
  - The site of the pain
- For back pain
  - Specify the site (e.g., low back, thoracic, cervical, etc.)
  - State the laterality when applicable (i.e., right, left or bilateral)

- Identify the underlying cause of the pain.
- Differentiate between panniculitis and radiculopathy.
- Detail when lumbago is accompanied by sciatica.



### **OSTEOPOROSIS**

- Indicate the presence or absence of current pathological fractures.
- Identify the current fracture site.
- Specify the healing status of the current fracture (e.g., routine, delayed, nonunion, malunion).
- Detail any past history of healed osteoporosis fractures.
- Provide information regarding the encounter type (e.g., subsequent, sequela).
- Clarify the cause (e.g., age-related, drug-induced, post-traumatic). If drug-induced list the specific drug.
- Report any major osseous defect.



### CONTACTS

If you have any questions or concerns about the information presented here, please contact Mary Ellen Reardon or Shannon Bujak-Chase and we will be glad to assist you.

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### **Thank You**