CLINICAL CONCEPTS FOR ORTHOPEDICS

CMS Clinical Concepts

ICD 10 LESSONS FROM OFFICE DOCUMENTATION

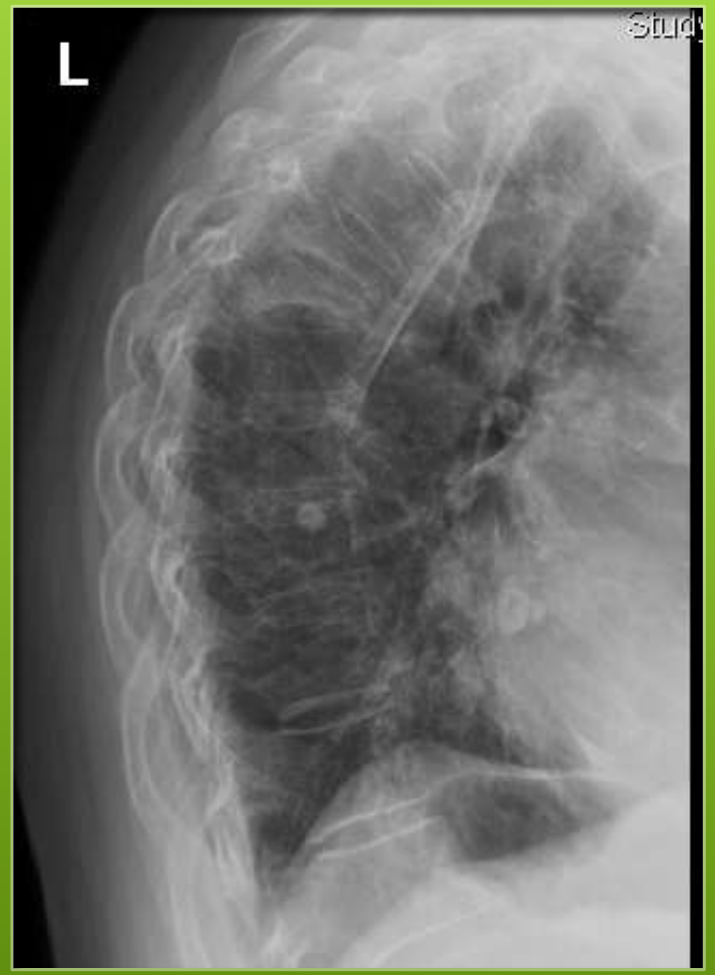
Presented by Dr. Frankeny

OUR CHALLENGE: CHANGING OUR DOCUMENTATION

ICD 10

- Learn the nomenclature
- Documenting enough elements to code all 7 characters required

Pre-authorizations for Tests, Surgeries, and DME



BALOG NOTE ONE

DIAGNOSIS: Osteoporosis with now two midthoracic compression fractures.

SPINE FRACTURE CODING OPTIONS

1. General
    1. Document which vertebrae
    2. Stable vs unstable
    3. Displaced versus nondisplaced
    4. Cervical
        1. C1
            1. Burst
            2. Posterior Arch
            3. Lateral Mass
            4. Other

SPINE FRACTURE CODING OPTIONS (CONT.)

4. Cervical (cont.)
    2. C2
        1. Type II Dens Fracture
            1. Anterior, Posterior displacement or non displaced
        2. Other Dens Fracture
            1. Includes Type I and III
        3. Other Fracture of C2
        4. Traumatic Spondylolisthesis of C2
            1. Non displaced, displaced, Type 3 displaced

SPINE FRACTURE CODING OPTIONS (CONT.)

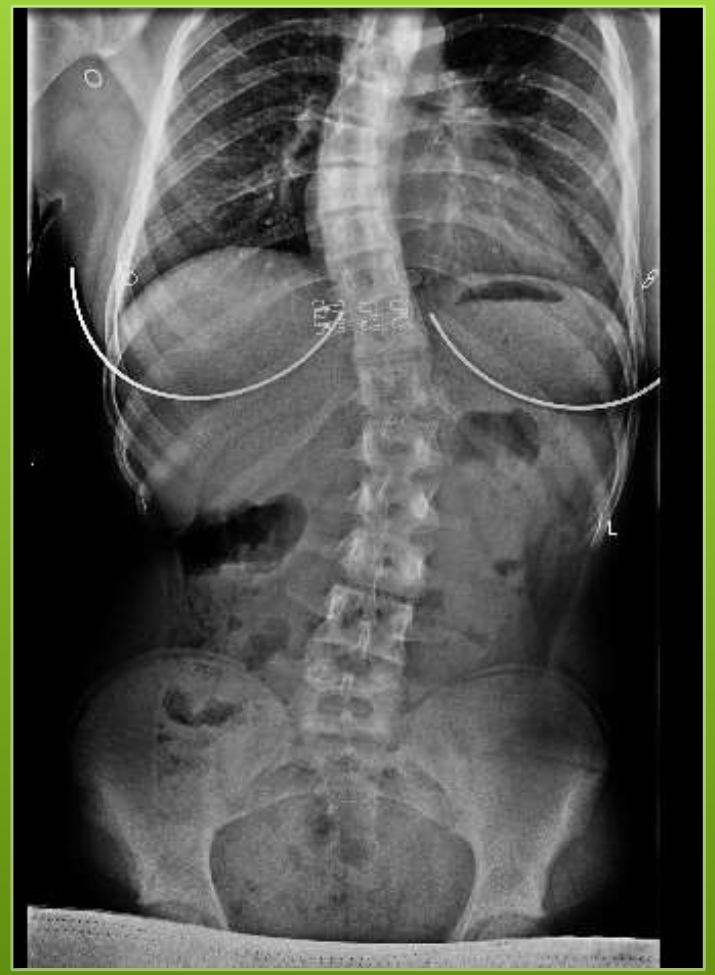
4. Cervical (cont.)
    3. C3-7
        1. Unspecified
            1. Nondisplaced, displaced
        2. Traumatic Spondylolisthesis
            1. Nondisplaced, displaced, Type III displaced
    4. All
        1. Subluxation by level: e.g. C3-4
        2. Dislocation by level

SPINE FRACTURE CODING OPTIONS (CONT.)

5. Thoracic and Lumbar Spine
    1. Document which level
    2. Fracture types
        1. Wedge Compression
        2. Burst
            1. Stable versus Unstable
        3. Other
    3. Subluxation and Dislocation at level e.g. T 6-7

SPINE FRACTURE CODING OPTIONS (CONT.)

6. Ribs
    1. Single or multiple
    2. Left or Right



BALOG NOTE TWO

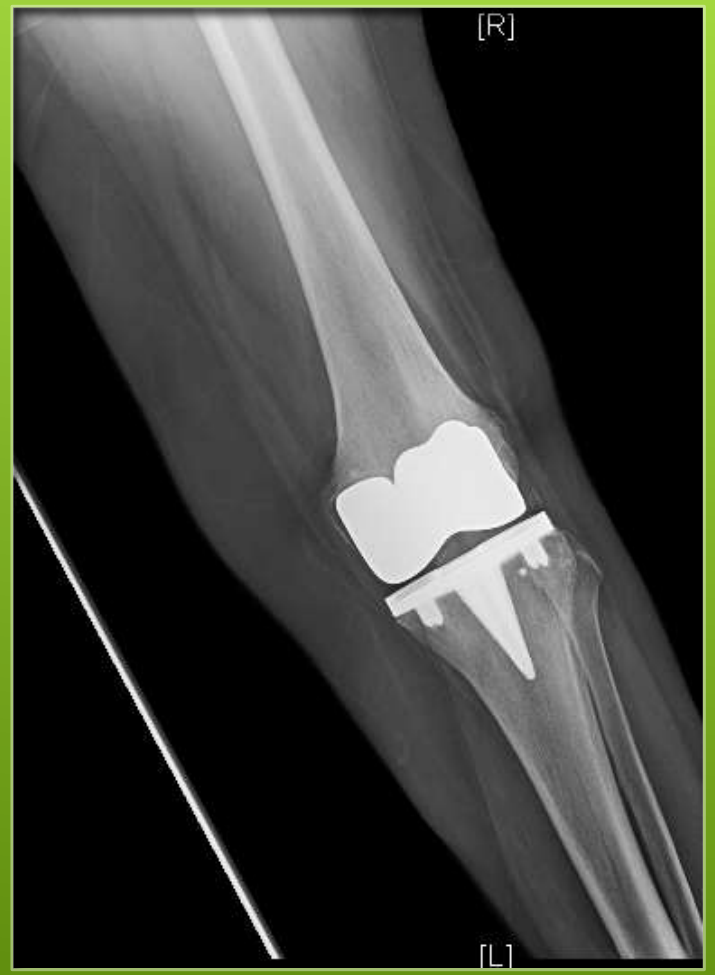
DIAGNOSIS: Idiopathic well balance scoliosis.

SPINE DEFORMITIES

1. Document for all
    1. Level
        1. Cervical, cervicothoracic, thoracic, thoracolumbar, lumbar, lumbosacral
2. Kyphosis and Lordosis
        1. Postural
        2. Unspecified
        3. Other secondary
            1. Post laminectomy
            2. Post surgical lordosis or flatback

SPINE DEFORMITIES (CONT.)

3. Scoliosis
    1. Congenital
        1. Due to bony malformation
    2. Infantile Idiopathic
    3. Juvenile Idiopathic
    4. Adolescent Idiopathic
    5. Neuromuscular
    6. Other Secondary (degenerative lives here)



BALOG NOTE FOUR

DIAGNOSIS: Left knee sprain, no evidence of fracture superimposed on otherwise well functioning left knee replacement.

KNEE SPRAINS

If you mention it, you have to say which ligament:

Collateral ligament: Lateral (fibular), Medial (tibial)

Cruciate ligament: Anterior, Posterior

Patellar ligament

Superior tibiofibular joint (ligament)

ALTERNATIVE TO KNEE SPRAIN

Specify left or right

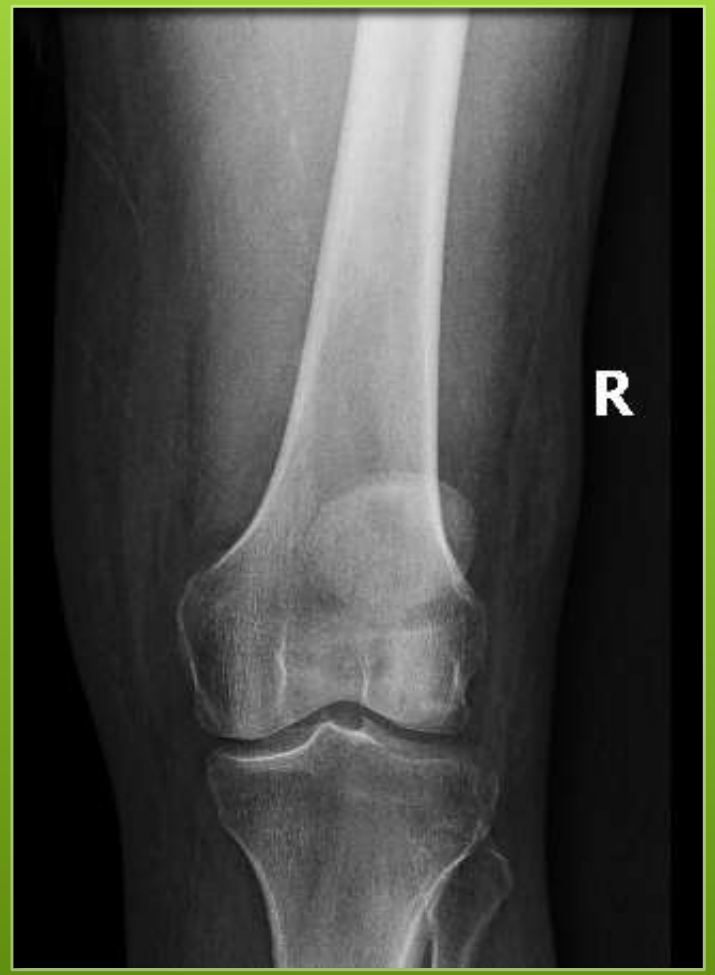
Contusion

Effusion

Pain

Stiffness

******Knee pain is not a diagnosis that supports medical necessity for dispensing a DME product**



BOAL NOTE ONE

DIAGNOSIS: End-stage degenerative arthritis of the right knee.

ARTHRITIS: THESE TYPES APPLY TO ALL JOINTS

1. Bilateral, Left, or Right, Specific Joint
    - Osteoarthritis
        - Primary
        - Post Traumatic
        - Other Secondary Osteoarthritis
            - Any and all other causes
            - E.g. Hip osteoarthritis secondary to Hip Dysplasia
    - Crystalline Arthritis
        - Gout
            - Idiopathic
            - Lead induced
            - Drug induced
            - Renal disease induced
            - Other secondary

ARTHRITIS (CONT.)

1. Bilateral, Left or Right, Specific Joint (cont.)
    - Crystalline Arthritis (cont.)
        - Calcium Deposition:
            - Hydroxyapatite Deposition Disease
            - Chondrocalcinosis
                - Familial
                - Other
    - Inflammatory Arthritis
        - RA seropositive
            - Without other organ or system involvement
            - With other organ or system involvement
        - RA seronegative
        - Juvenile RA

ARTHRITIS: THESE APPLY TO ALL JOINTS

. Bilateral, Left or Right, Specific Joint (cont.)

- Reactive Arthritis
  - Due to an infection elsewhere in body (previously Reiter's syndrome)
  - Post Intestinal Bypass
  - Post Dysenteric
  - Post Immunization
  - Other
- Neuropathic: Charcot

ARTHRITIS: THESE TYPES APPLY TO ALL JOINTS

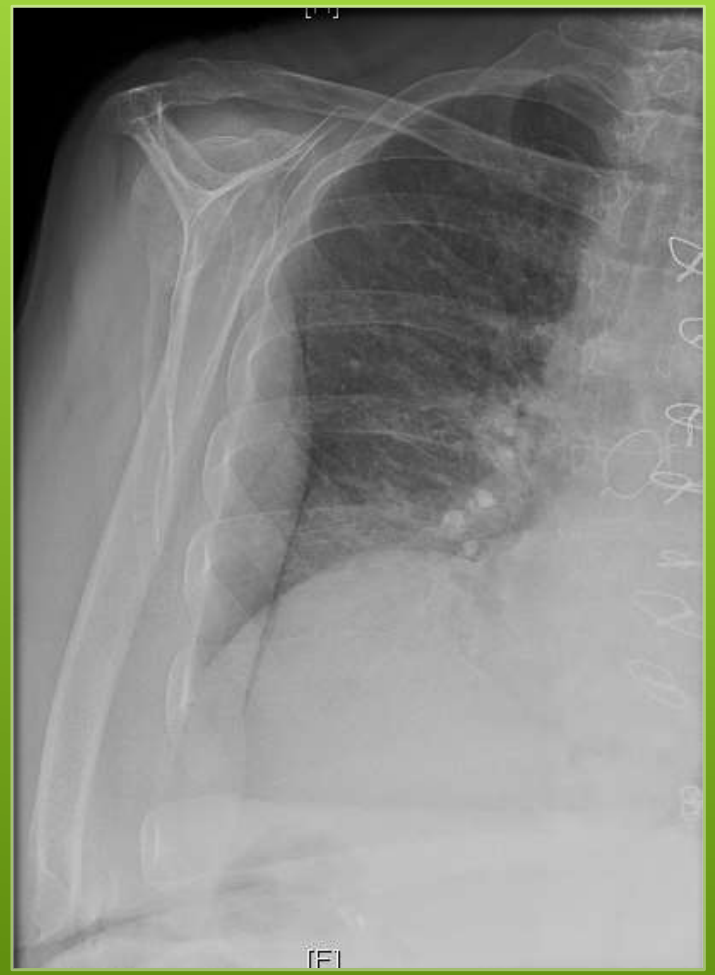
1. Bilateral, Left or Right, Specific joint (cont.)
    - Infectious Arthritis
        - Pyogenic Arthritis
            - Staph
            - Strep
            - Pneumococcal
            - Other Bacteria
        - Lyme
        - Gonococcal
        - TB

BUERK NOTE THREE

DIAGNOSIS: Right ankle sprain.

ANKLE SPRAIN TYPES

1. Calcaneofibular (lateral)
2. Deltoid
3. Tibial-Fibular



BUERK NOTE FOUR: PROXIMAL HUMERUS FRACTURE

DIAGNOSIS: Right proximal humerus fracture, healing well.

SHOULDER

1. Arthritis
    1. See Above
2. Instability
    1. Dislocation or subluxation Glenohumeral Joint
        1. Anterior, posterior, inferior, or other
            1. Congenital
            2. Pathological
            3. Traumatic
            4. Recurrent

SHOULDER (CONTINUED)

3. Instability (cont.)
    1. AC joint
        1. Subluxation (previously Grade 1)
        2. Dislocation 100-200% (previously Grade 2)
        3. Dislocation >200%
        4. Inferior
        5. Posterior
    2. SC Joint
        1. Anterior
        2. Posterior

SHOULDER (CONTINUED)

Subacromial Pathology

1. Impingement syndrome
2. Bursitis
3. Calcific Tendinitis
4. Bicipital Tendinitis and Rupture
5. Chronic Rotator Cuff Tear
    1. Incomplete
    2. Complete
6. Acute Rotator Cuff Tear

SHOULDER (CONTINUED)

5. Fractures
    1. Surgical Neck
        1. 2, 3, 4 part
        2. Greater Tuberosity
        3. Lesser Tuberosity

DAHL NOTE TWO

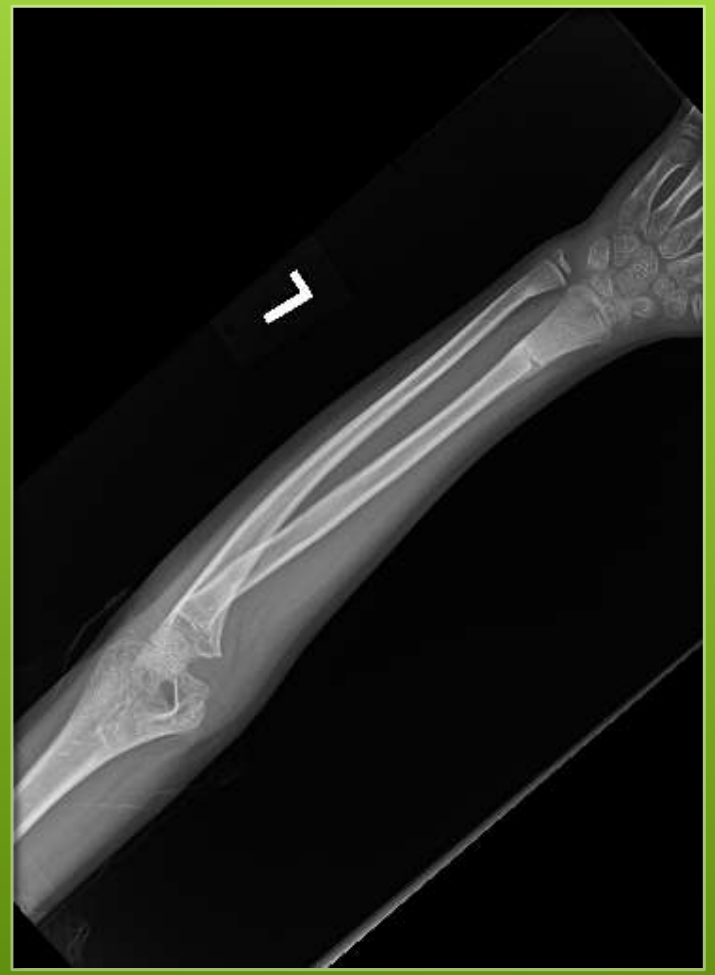
DIAGNOSIS: Right foot sprain/strain.

SPRAIN/STRAIN FOOT

Must specify ligament

Tarsal ligament

Tarsometatarsal ligament



DAHL NOTE FOUR

DIAGNOSIS: Buckle fracture, left distal ulnar shaft and distal radial shaft.

MUST DOCUMENT FOR ALL FRACTURES

Initial versus subsequent encounter

Laterality: Left vs Right

Fracture Pattern: Transverse, oblique, spiral, comminuted

Non-Displaced versus Displaced

Closed versus Open (then Gustillo type)

Anatomy: Epiphysis, Metaphysis, Diaphysis, Proximal, Distal

Type: Colles, Barton's, Salter type, etc.

Underlying Cause: Traumatic (describe), pathological, stress

Underlying Disease: Osteoporosis?

Healing process: routine, delayed, nonunion, malunion

E.G.

History: "This is the 6 week follow up visit for this 79 year old…."

X-ray: "Two views of the left wrist reveal a transverse, non-displaced, closed, distal radius Colles type fracture that is healing routinely."

Impression: "Left distal radius, transverse, non-displaced, closed, Colles type fracture secondary to a fall, with a history of osteoporosis. The fracture appears to be healing routinely."

Yes, it is suggested that you describe the fracture in the x-ray and impression sections!!

DAHMUS NOTE TWO

DIAGNOSIS: Right patella fracture.

MUST DOCUMENT TYPE OF FRACTURE

Comminuted (displaced)

Comminuted Non displaced

Longitudinal (displaced)

Longitudinal Non displaced

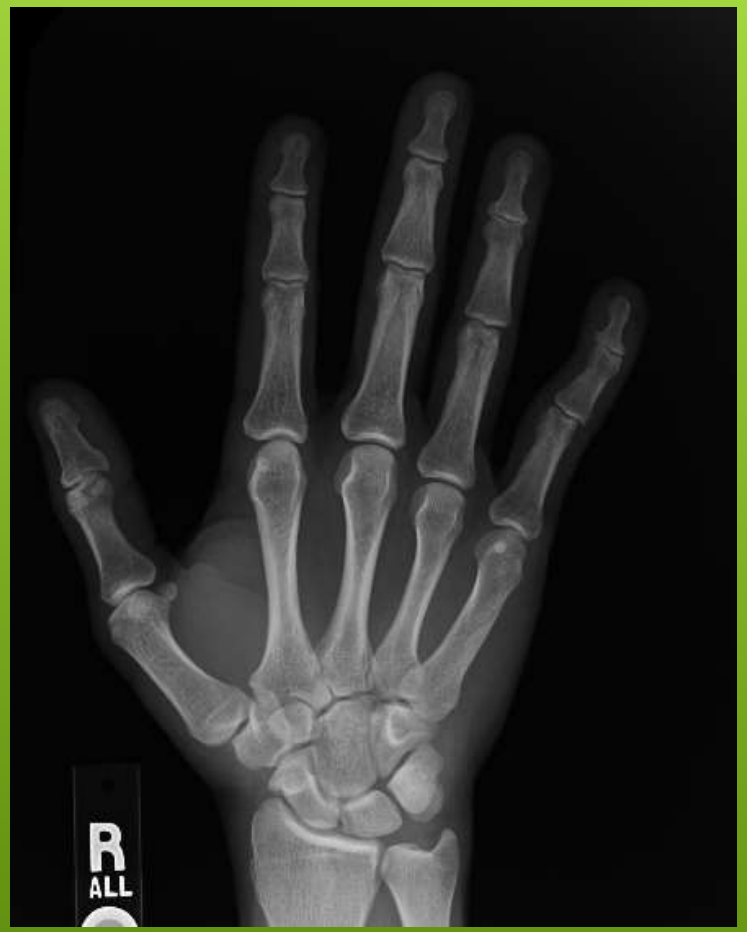
Osteochondral (displaced)

Osteochondral Non displaced

Transverse (displaced)

Transverse Non displaced

REMEMBER ALL FRACTURES ALL NEED COMPREHENSIVE FRACTURE DOCUMENTATION!



DAILEY NOTE THREE

Right 5th metacarpal fracture

TYPE OF FRACTURE / LOCATION OF FRACTURE

Displaced versus Non Displaced

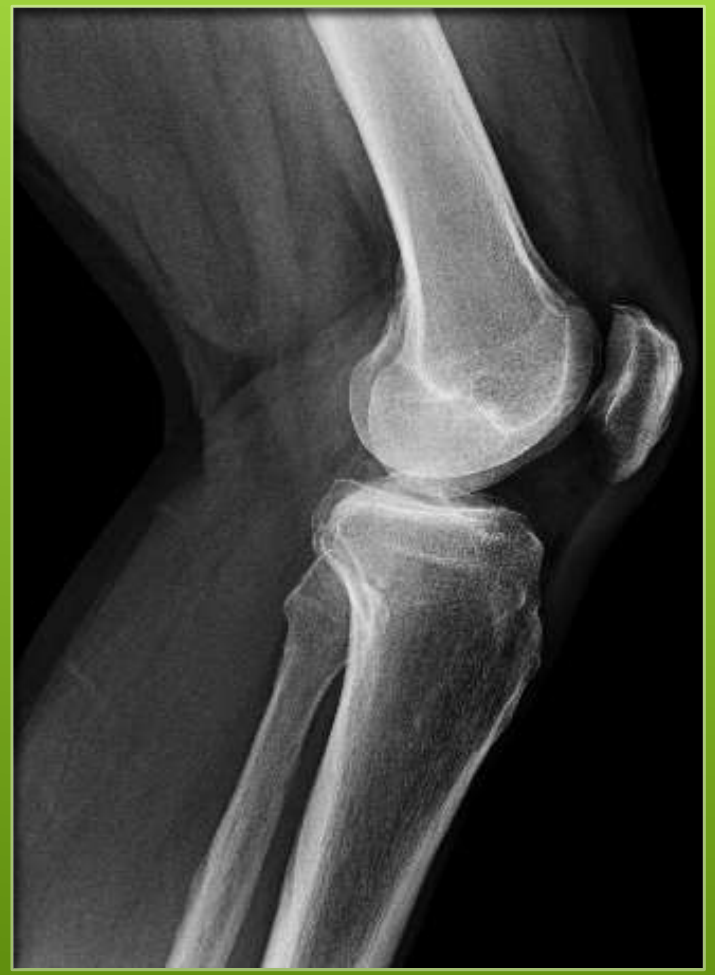
Base

Shaft

Neck

Label type of metacarpal fracture e.g. Bennetts, Rolando's, Boxers

REMEMBER ALL FRACTURES ALL NEED COMPREHENSIVE FRACTURE DOCUMENTATION!



DEMUTH NOTE FOUR

Left knee medial meniscus tear with instability

MENISCUS TEAR

Left or Right

Medial or Lateral

Old injury or tear:

Anterior horn

Posterior horn

Bucket Handle

Degenerative, Cystic

New Injury or tear:

Bucket Handle

Complex

Peripheral

Other

HELY NOTE THREE

DIAGNOSIS: Left shoulder sprain, definite improvement over the past week.

SHOULDER SPRAIN

Dislocation or Subluxation:

Anterior

Posterior

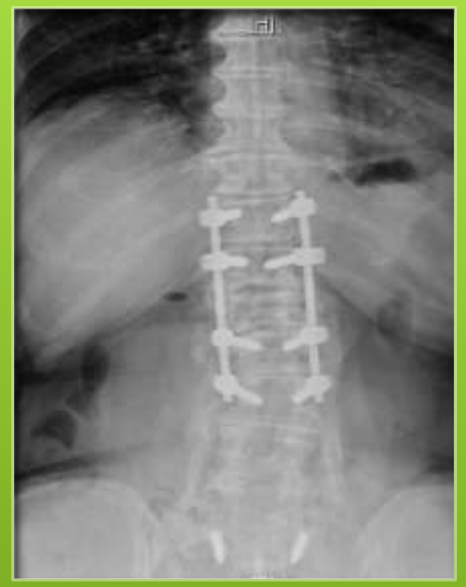
Inferior

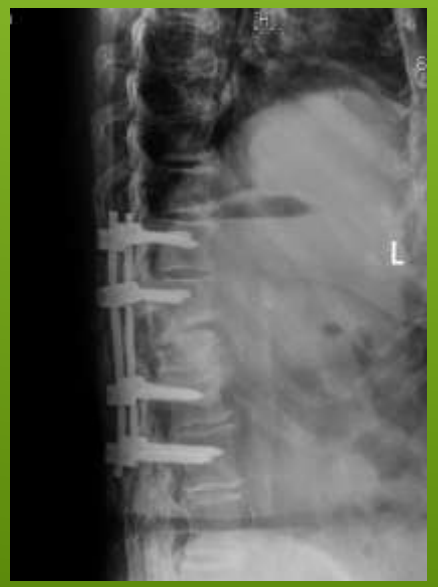
Sprain of the Shoulder:

Coracohumeral ligament

Rotator cuff

Superior labrum





WOLF NOTE THREE

DIAGNOSIS: Spinal stenosis, with kyphosis, degenerative disc disease, she is secondary to pain thoracolumbar spine reconstruction.

SPINAL STENOSIS

Must specify the location of stenosis

Occipito-atlanto-axial region
Cervical Region
Cervicothoracic Region
Thoracic Region
Thoracolumbar Region
Lumbar Region
Lumbosacral Region
Sacral and Sacroccygeal Region

DEGENERATIVE DISC DISEASE

Must document levels

Occipito-atlanto-axial, cervical, cervico-thoracic, thoracic, thoracolumbar, lumbar, lumbosacral, sacral

Spondylosis

- With or without myelopathy or radiculopathy

- Disc Disorder or Displacement or Degeneration
  - With or without myelopathy or radiculopathy
- Sciatica
  - With or without lumbago or lumbar pain
- Radiculopathy
  - Document level

HORGAN NOTE ONE

Gout right ankle

GOUT

Type of gout needs to be documented

Idiopathic

Lead Induced

Drug Induced

Gout due to renal impairment

Other secondary gout

Gout unspecified

OUR CHALLENGE: CHANGING OUR DOCUMENTATION

ICD 10

- Learning the nomenclature
- Documenting enough elements to code all 7 characters

Pre-authorizations for Tests, Surgeries, and DME

MEMORY AIDS AND REFERENCES

On the walls of the cubicles: General Documentation Guidelines and ICD 10 fracture documentation

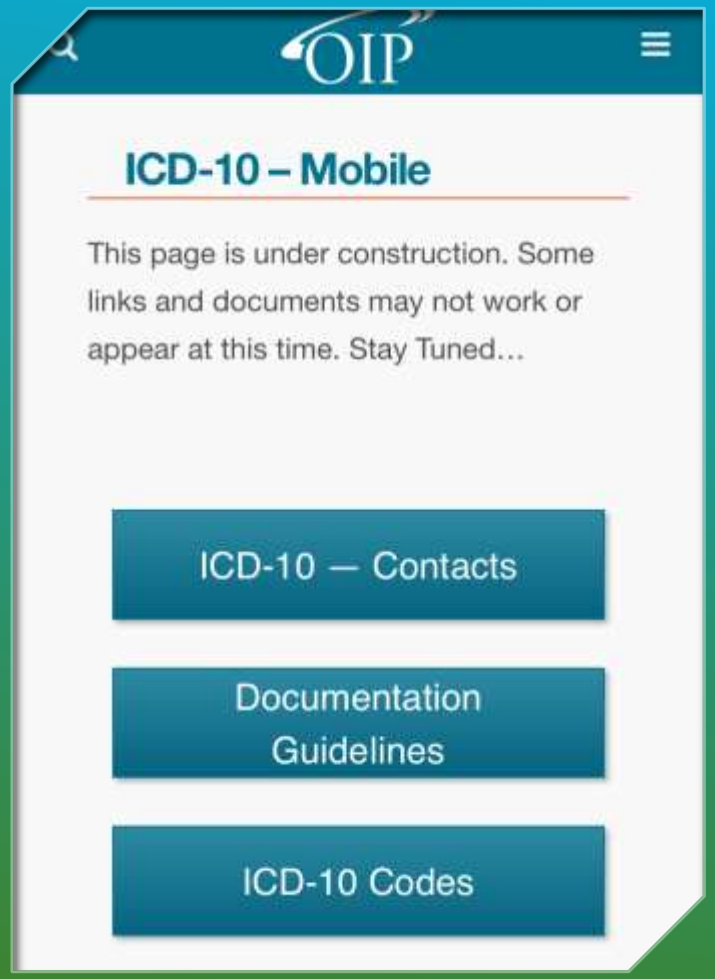
In the Documentation Guidelines spiral notebooks: ICD 10 and Pre-authorization

On the Share Drive

Half Sheet changes to incorporate ICD documentation

Changes to Router to better match ICD 10 documentation

Via the link on our mobile website (blocked to public access)



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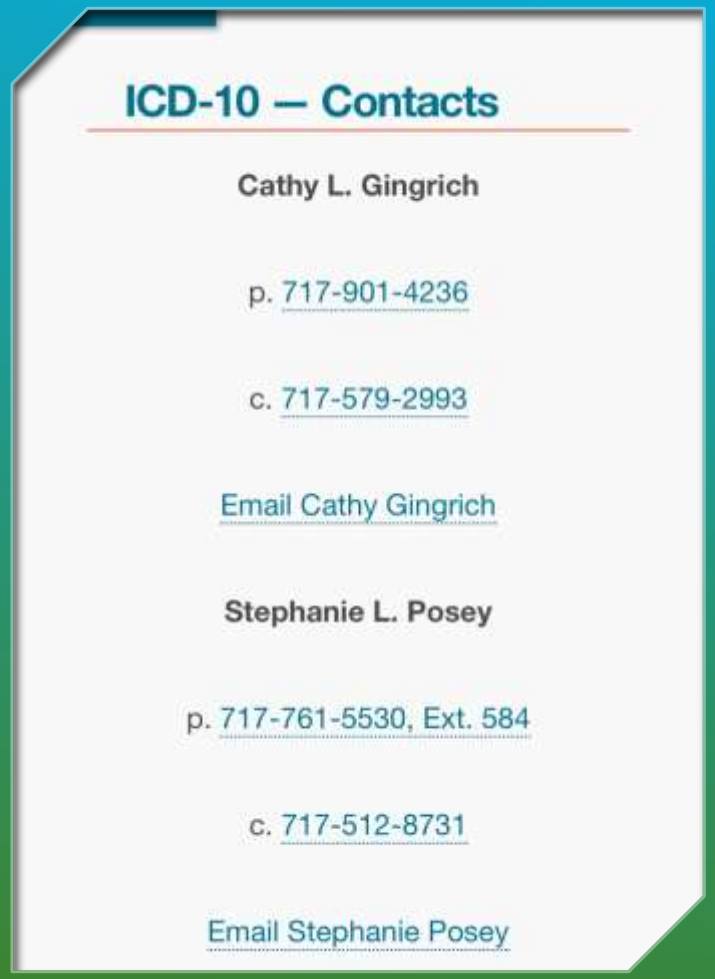
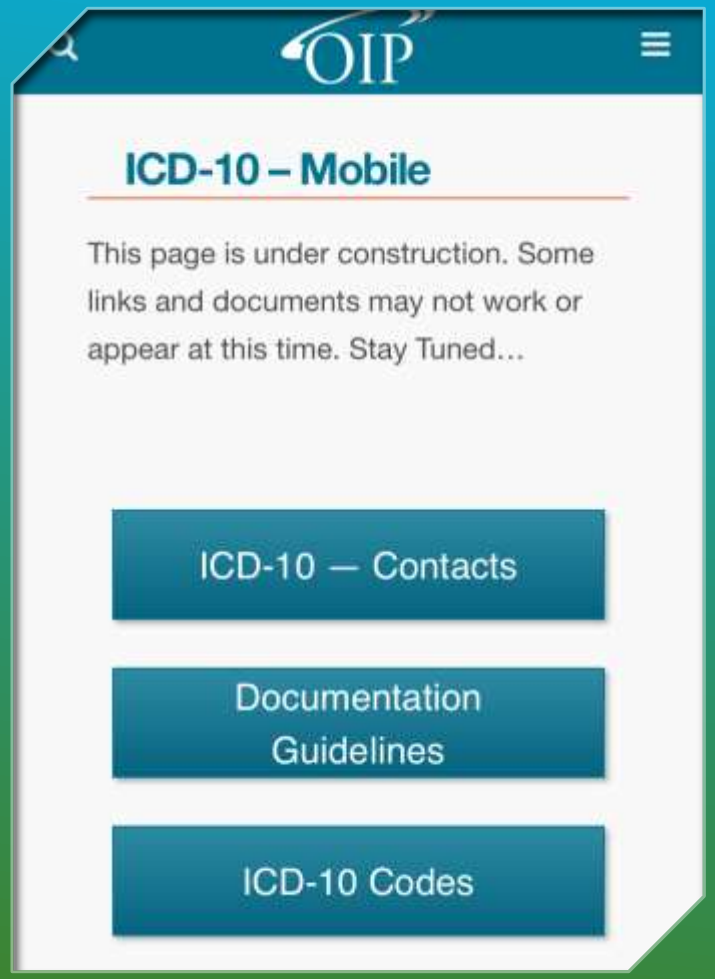


ICD 10 MOBILE CONTACTS



ICD 10 MOBILE

http://www.oip.com/icd10-mobile

ICD 10 MOBILE

Documentation Guidelines

ICD-10 GENERAL DOCUMENTATION GUIDELINES

I. HISTORY

a. HPI:

i. Must include all of these elements that apply:

1. **Episode**: "first visit" "follow up visit"
2. **Location/laterality**: "Proximal" "metaphyseal" L vs R
3. **Cause/contributing factors**: External factors must be described specifically
4. **Place of occurrence**
5. **Symptoms**
6. **Severity**
7. **Temporal factors:** Start, end, duration, dates
8. **Associated Symptoms**
9. **Complicated by:**
10. **History of** anything from PMH affects presenting problems

b. PREVIOUS TREATMENT for **Preauthorization** for epidurals, MRI, visco, surgeries: **Consult Guidebooks**

i. Must document all prior treatments: Epidurals, MRIs, Visco, TJR

1. **Activity Modification:** What, how long, and results
2. **Medication**: name of med, duration, and results
3. **Cortisone:** when and results
4. **PT or physician directed home exercises:** must be within last 6 months: for TJR, need 12 weeks or reason why patient could not tolerate.
5. **Chiropractic care:** dates and results
6. **Effects on ADLs:** specifically
7. **Assistive Devices:** For TJR: for 12 weeks and if not used must document why.

II. PHYSICAL EXAM:

a. E & M CODING:

i. Level 1 initial visit: 1-5
ii. Level 2 initial visit: at least 6
iii. Level 3 initial visit: at least 12
iv. Level 4 initial visit: all elements
v. Level 5 initial visit: all elements

i. Level 1 F/U visit: None
ii. Level 2 F/U visit: 1-5
iii. Level 3 F/U visit: at least 6
iv. Level 4 F/U visit: at least 12
v. Level 5 F/U visit: all elements

For ICD 10, if applies, must include.

1. **General Appearance**
2. **Mood/Affect**
3. **Orientation**
4. **VS/Weight/Height**
5. **Vascular Exam**
6. **Lymphatics**
7. **Gait/Station**
8. **Coordination**
10. **Sensation**
11. **Strength**
12. **Inspection/palpation**
13. **ROM**
14. **Stability**
15. **Skin**
16. **Anatomy** (specific tendon, ligament, etc)
17. **Morphology:** (deformity, etc)

b. FOR PREAUTHORIZATION:

i. Epidurals: Any of the following:

1. Weakness, sensory loss, reflex loss, pain concordant with studies

ii. Total Joints: Must comment on all of the following

1. Pain with WB and ADLs
2. Swelling
3. Deformity
4. Crepitation
5. Antalgic gait
6. Stability
7. ROM amount, painful?
8. Skin, neurovasc status

III. DIAGNOSTIC TESTS:

a. FOR PREAUTHORIZATION:

i. Epidurals: Concordant MRI, EMG

General Documentation Guidelines

ii. Visco: Imaging documenting moderate to severe DJD
iii. TJR: Xrays must document: at least two: joint space narrowing, subchondral cysts or sclerosis, spurs

IV. **ASSESSMENT/DIAGNOSIs:**

a. **Be as Specific as possible!!** Here is where you make up lost ground if your haven't documented in HPI and PE.

i. **Anatomy:** Be specific as possible: Which bone, which ligament, etc

ii. **Type:** This is the essence of ICD 10: specifity. Call it by its orthopedic name: Colles

1. Examples:
2. : "Right, distal, metaphyseal, non-displaced, non-comminuted, transverse closed Colles Fracture"
3. More to come

iii. **Episode:**

1. Initial encounter or subsequent encounter

iv. **Sequelae:**

1. Example: Fracture
   a. Routine healing
   b. Delayed healing
   c. Non-union
   d. Mal-union
2. Others to come
   a. Just describe usual or any deviation from usual healing

v. **E & M Complexity**

a. Level 3 and higher, some complexity

V. **PLAN:**

a. **Document** so that another doctor could take over care.

b. **Liability Protection Documentation**

c. **If you order a brace: DME Documentation:**

i. Every note should address the patients' ambulatory status, the weakness of a body part and the instability of a body part- otherwise they really don't need something to support them and hold them up.

1. **Ambulatory status**- non weight bearing, partial weight bearing or full weight bearing
2. **Weakness**- be specific about what is weak and needs support
3. **Deformity**- what doesn't look like it is supposed to on a healthy individual (the development of arthritis in a joint is a deformity)
4. **Instability/laxity**- be specific about what is unstable and how you determined it (varus valgus instability, positive anterior/posterior drawer test)

ii. The note should also include:

1. **What product** are they to receive
2. **Why** are we prescribing the product?
   a. To provide **stabilization**
   b. To **improve function**
   c. To **reduce pain**
   d. To **facilitate healing**
3. **How** is the patient to **use** the product?
   a. Wear at all times
   b. Remove for hygiene only
   c. Use during ambulation
   d. Remove to sleep
   e. When should they start using it (the day they receive it, not until post-op, starting in two weeks, etc)

General Documentation Guidelines

ICD 10 MOBILE

Documentation Guidelines

Fracture Coding ICD 10:

Initial versus subsequent encounter

Laterality: Left vs Right

Fracture Pattern: Transverse, oblique, spiral, communuted

Non-Displaced versus Displaced

Closed versus Open (then Gustillo type)

Anatomy: Epiphysis, Metaphysis, Diaphysis, Proximal, Distal

Type: Colles, Barton's, Salter type, etc

Underlying Cause: Traumatic (describe), pathological, stress

Underlying Disease: Osteoporosis?

Healing process: routine, delayed, nonunion, malunion

E.G.

History: "This is the 6 week follow up visit for this 79 year old…."

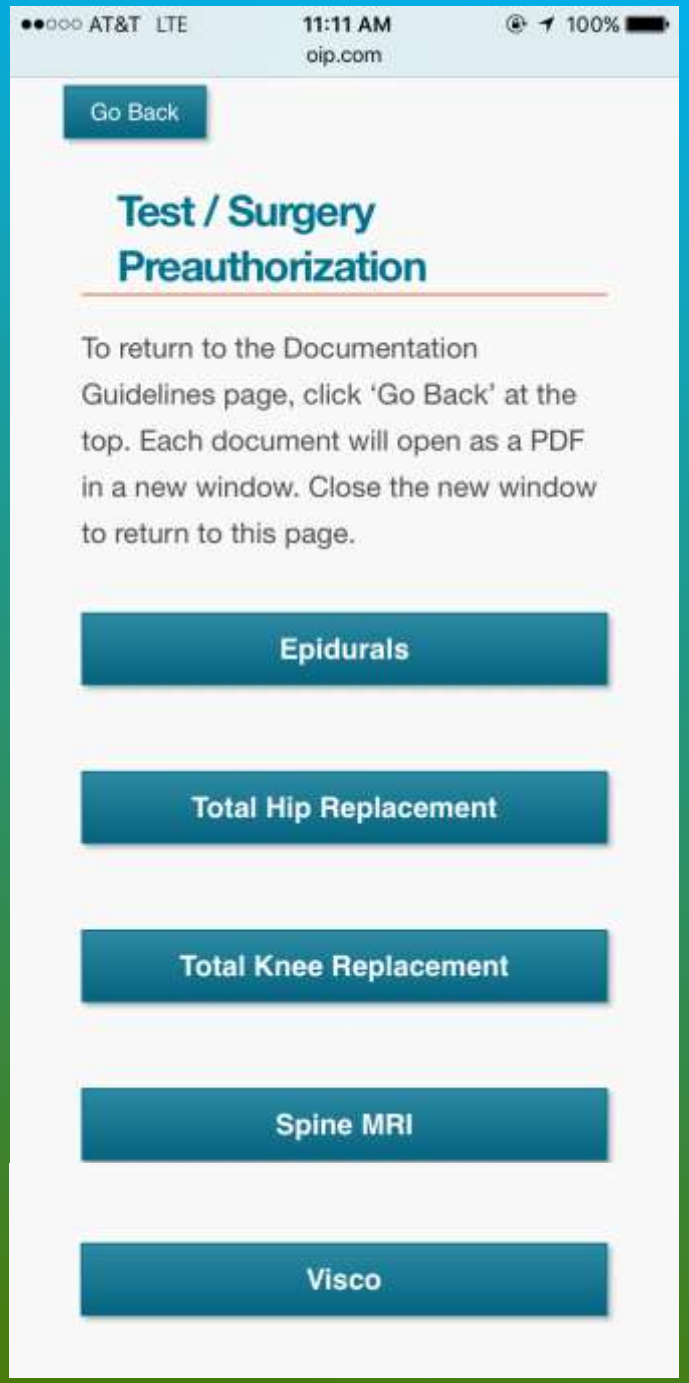
Xray: "Two views of the left wrist reveal a transverse, non-displaced, closed, distal radius Colles type fracture that is healing routinely."

Impression: "Left distal radius, transverse, non-displaced, closed, Colles type fracture secondary to a fall, with a history of osteoporosis. The fracture appears to be healing routinely."

Yes, it is suggested that you describe the fracture in the xray and impression sections!!

ICD 10 MOBILE

Documentation Guidelines



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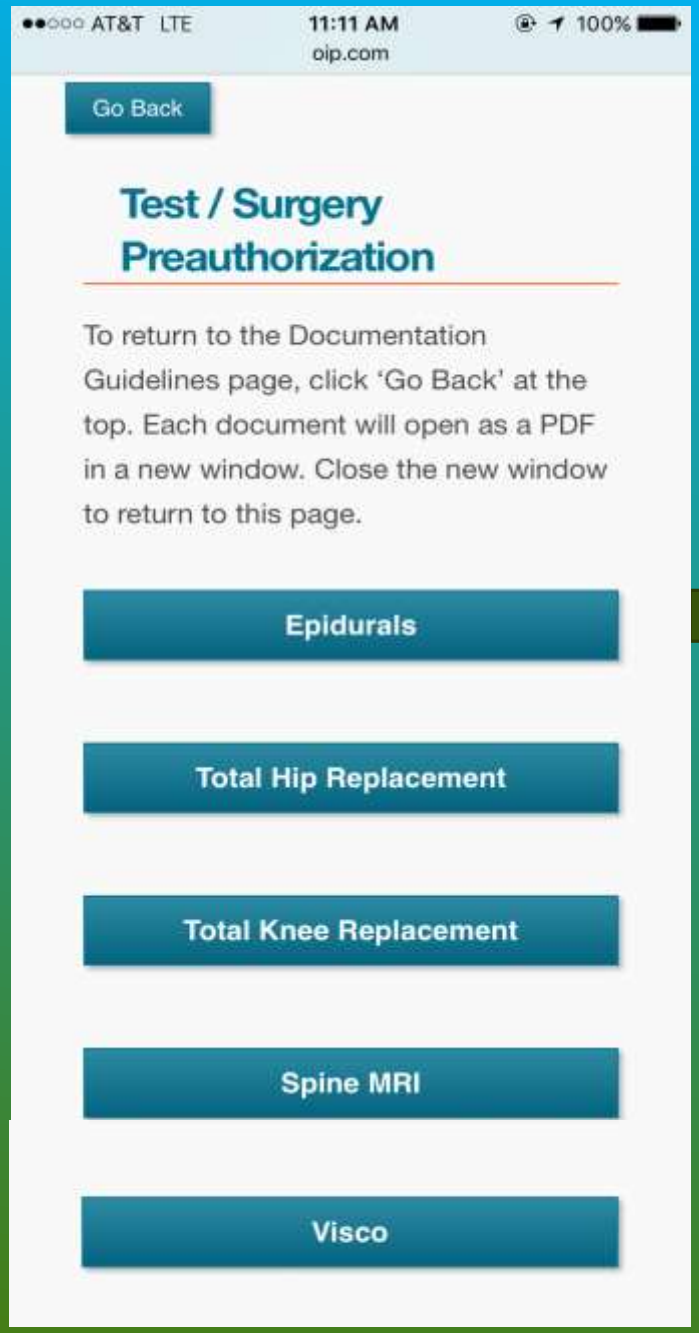
Test/Surgery Preauthorization



Epidurals

Preauthorization Documentation Requirements

History: Must include **ALL** listed below

Must document all conservative treatment including what, how long and results:

1) Formal PT or a **physician directed** home exercise program and the results – must be within 6 months. Documentation must include the words formal or physician directed.
2) Activity modification – what, how long and results
3) ADLs – how are they affected
4) Medications – specific name, length of time used and results

Physical Exam:

Radiculopathy must be documented by the presence of **ANY** of the following:

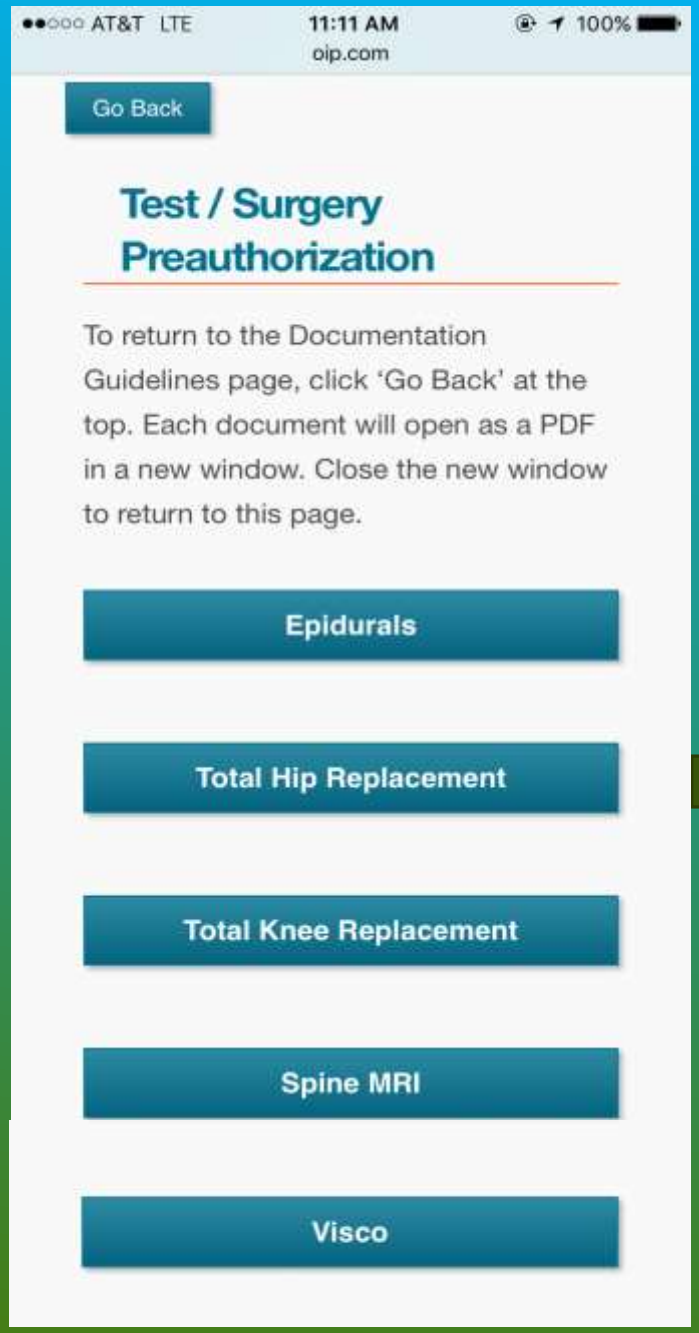
1) Loss of strength of specific named muscle (s) or myotomal distribution (s) demonstrated on detailed neurologic examination within the prior 3 months concordant with nerve root compression of the involved named spinal nerve root (s).

2) Altered sensation to light touch, pressure, pin prick or temperature demonstrated on a detailed neurologic examination (within the prior 3 months in the sensory distribution concordant with nerve root compression of the involved named spinal nerve root (s)

3) Diminished, absent or asymmetric reflex (es) concordant with nerve root compression of the involved named spinal nerve root (s).

4) Pain or other dysaesthesia/paraesthesia reported by the patient in a sensory distribution (specific dermatone) of the involved named spinal nerve root (s) with either of the following:

   a. A concordant radiologist's interpretation of an advanced diagnostic imaging study (MRI or CT) of the spine demonstrating compression of the involved named spinal nerve root (s). This must be performed with the prior 12 months.
   b. EMG/NCV's diagnostic of nerve root compression of the involved named spinal nerve root (s). Must be performed within the prior 12 months.



TOTAL HIP REPLACEMENT

Preauthorization Documentation Requirements

HISTORY: Must include **ALL** listed below

Must document all conservative treatment including what, how long and results OR explanation of why conservative treatment was not tried

1) Well-controlled medical conditions/co-morbidities and no active infection
2) Trial of medication – why did it fail – was it contraindicated
3) Level of pain
    a. Onset and Duration of symptoms
    b. Location and severity of pain
    c. Is it worsening?
    d. Increased with weight bearing?
    e. Interferes with ADLs and/or activities, walking distance, driving, steps
4) Failure of injections, conservative care
5) Must have 12 weeks of formal PT or **Supervised/Physician Directed** or it must be documented why patient could not tolerate it
6) Brace, cane, crutches and/or walker – must use for 12 weeks and if not used must document why

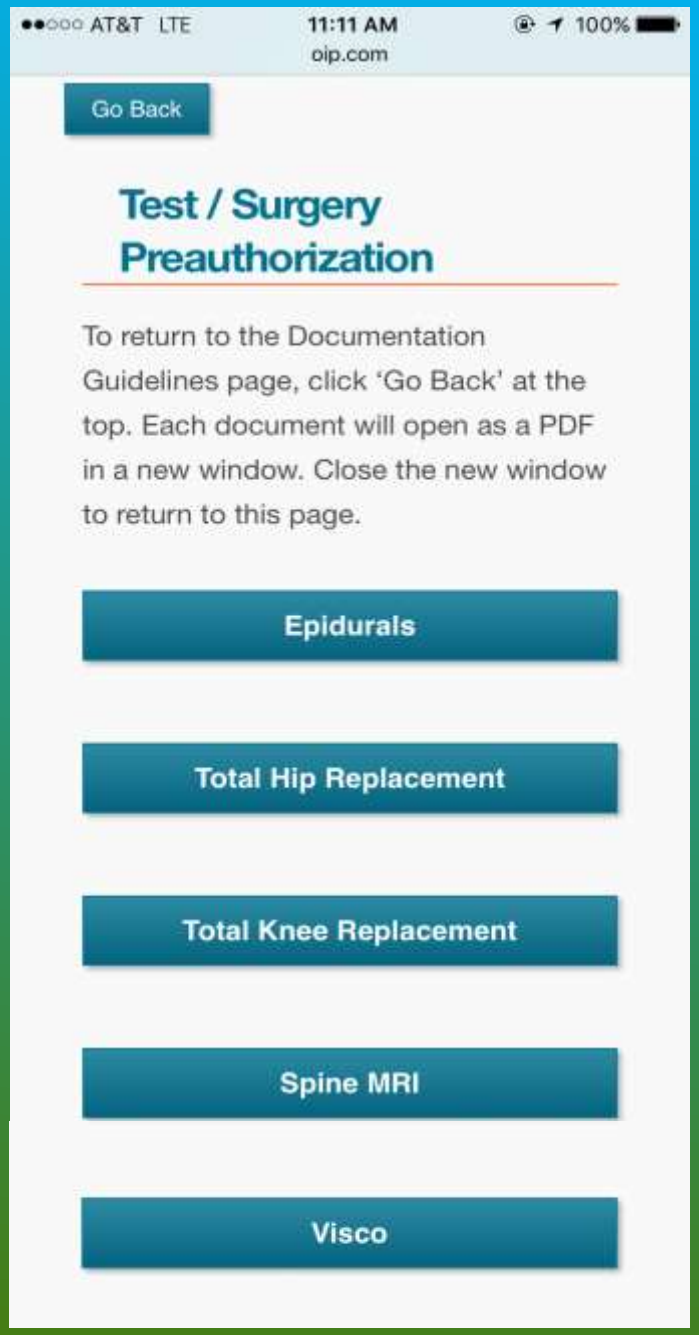
EXAM: Must include **ALL** listed below

1) Pain at the joint increased with WB and ADLs
2) Joint swelling or effusion – both current and/or past
3) Deformity present or absent
4) Crepitus – yes or no
5) Antalgic gait – yes or no
6) Stability of knee
7) Skin assessment and documentation of the presence or absence of pulses
8) Documentation of ROM – pain with passive ROM, limited ROM

X-RAYS: Must show **TWO (2)** of the following

1) Subchondral Cysts
2) Joint space narrowing
3) Subchondral sclerosis
4) Periarticular osteophytes
5) Joint subluxation

PLAN: Shared decision making must be clearly documented



TOTAL KNEE REPLACEMENT

Preauthorization Documentation Requirements

HISTORY: Must include **ALL** listed below

Must document all conservative treatment including what, how long and results OR explanation of why conservative treatment was not tried

1) Well-controlled medical conditions/co-morbidities and no active infection
2) Trial of medication – why did it fail – was it contraindicated
3) Level of pain
    a. Onset and Duration of symptoms
    b. Location and severity of pain
    c. Is it worsening?
    d. Increased with weight bearing?
    e. Interferes with ADLs
4) Failure of injections, conservative care
5) Must have 12 weeks of formal PT or **Supervised/Physician Directed** or it must be documented why patient could not tolerate it
6) Brace, cane, crutches and/or walker – must use for 12 weeks and if not used must document why

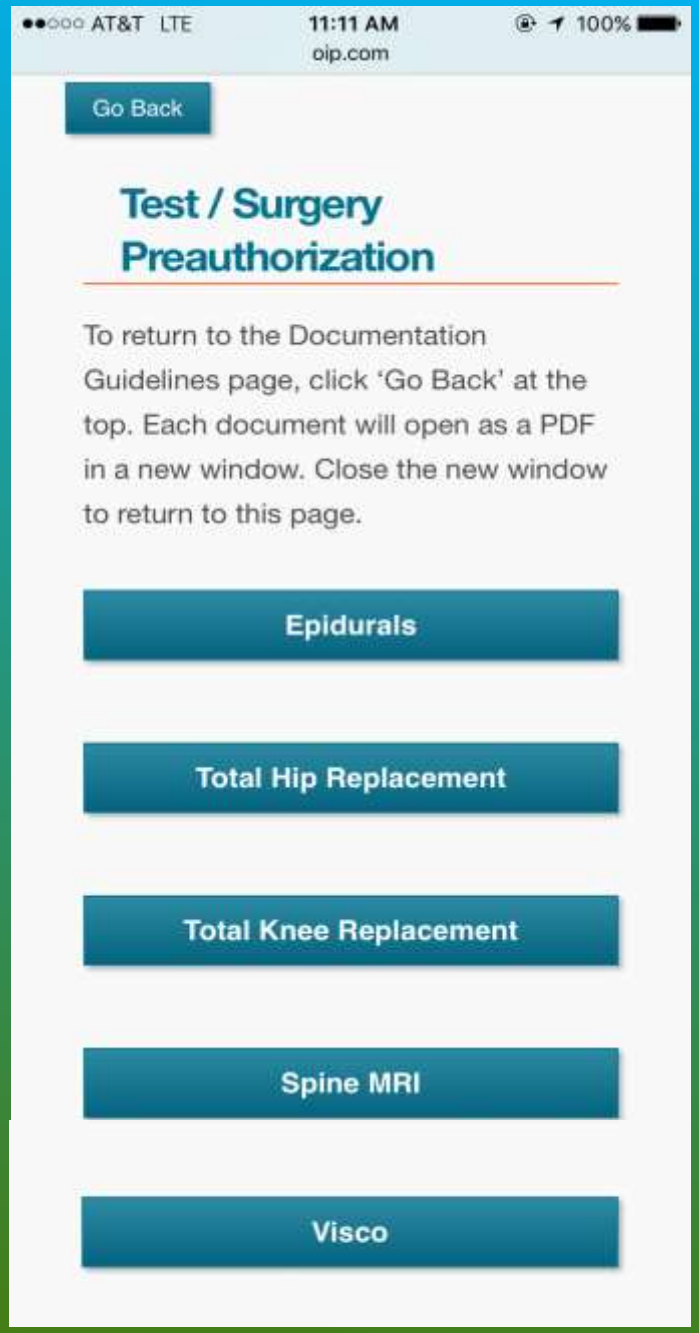
EXAM: Must include **ALL** listed below

1) Pain at the joint increased with WB and ADLs
2) Joint swelling or effusion – both current and/or past
3) Deformity present or absent
4) Crepitus – yes or no
5) Antalgic gait – yes or no
6) Stability of knee
7) Skin assessment and documentation of the presence or absence of pulses
8) Documentation of ROM – pain with passive ROM, limited ROM

X-RAYS: Must show **TWO (2)** of the following

1) Subchondral Cysts
2) Joint space narrowing
3) Subchondral sclerosis
4) Periarticular osteophytes
5) Joint subluxation

PLAN: Shared decision making must be clearly documented



SPINE MRI

Preauthorization Documentation Requirements

History: Must include **ALL** listed below

Must document at least six weeks of all conservative treatment including what, how long and results. If the patient failed any of this conservative treatment, **this must be documented in the physician's HPI.**

1) Supervised home exercise program OR formal physical therapy – need dates of treatment and results
2) Chiropractic treatment – need dates of treatment and results.
3) Epidurals – must have dates given
4) Medication – specific name, start date and length of time taken and results
5) ADLs – how are they affected

Physical Exam:

1) Radiculopathy – if present must document the specific dermatome distribution. If EMG/NCS was done and is abnormal the results must be documented in physical exam
2) Detailed description of any weakness that is present
3) Reflex exam – detailed description of any abnormalities

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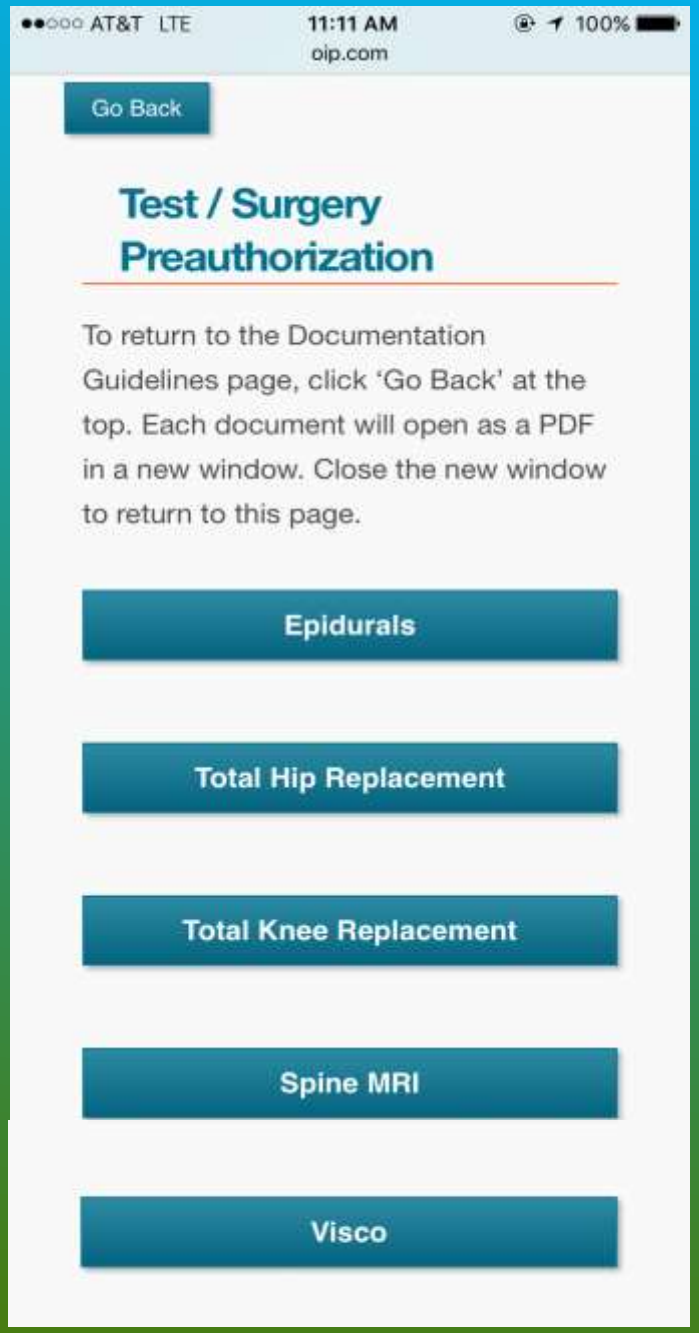


Viscosupplementation

Preauthorization Documentation Requirements

History: **ALL** listed below much be included

Must document all conservative treatment including what, how long and results

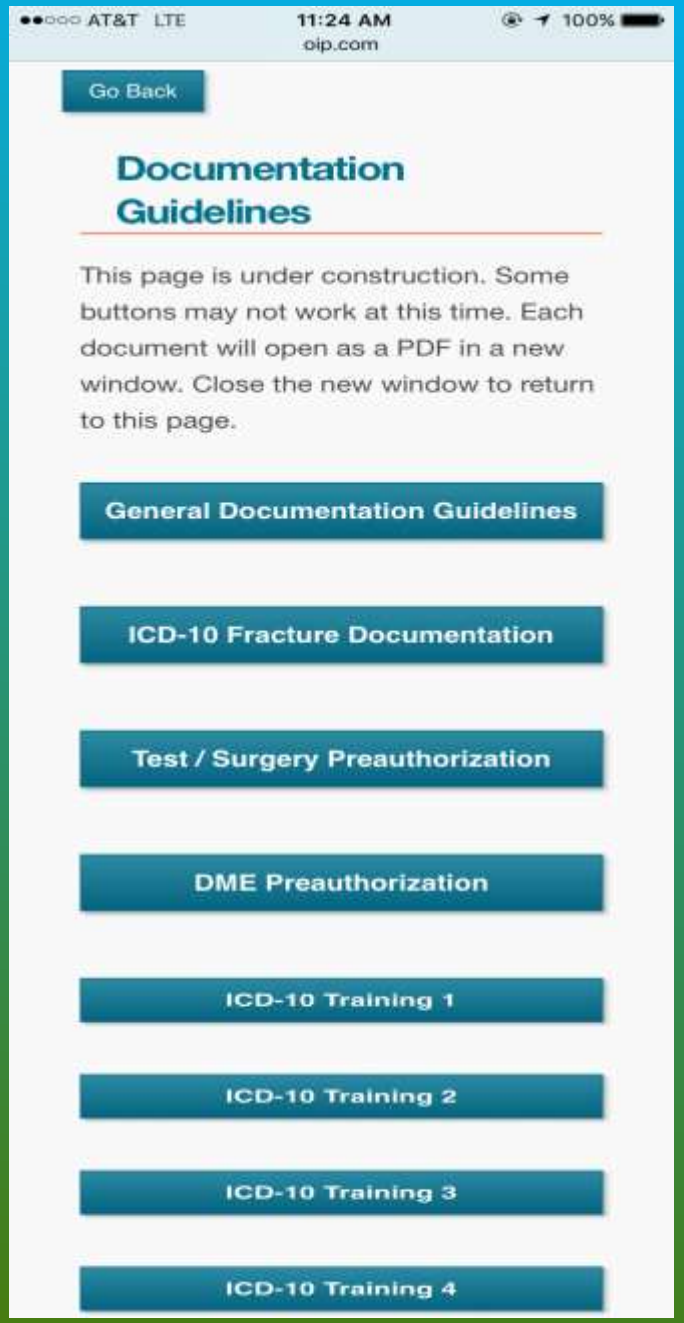
1) Medications – specific name, length of time used and results
2) Prior cortisone injections – when and results
3) Formal physical therapy or **Supervised/Physician Directed** home exercise program - when and results
4) How ADLs are affected

Diagnostic Testing:

1) X-ray, MRI, CT **OR** Ulrasound within one year stating moderate to severe DJD

Repeat Viscosupplementation

1) Must be six months and one day from last visco injection
2) Must document percentage of decrease in pain and use of pain medication
3) Must document percentage increase in ADLs or specific ADL, i.e. can walk further distances, etc.



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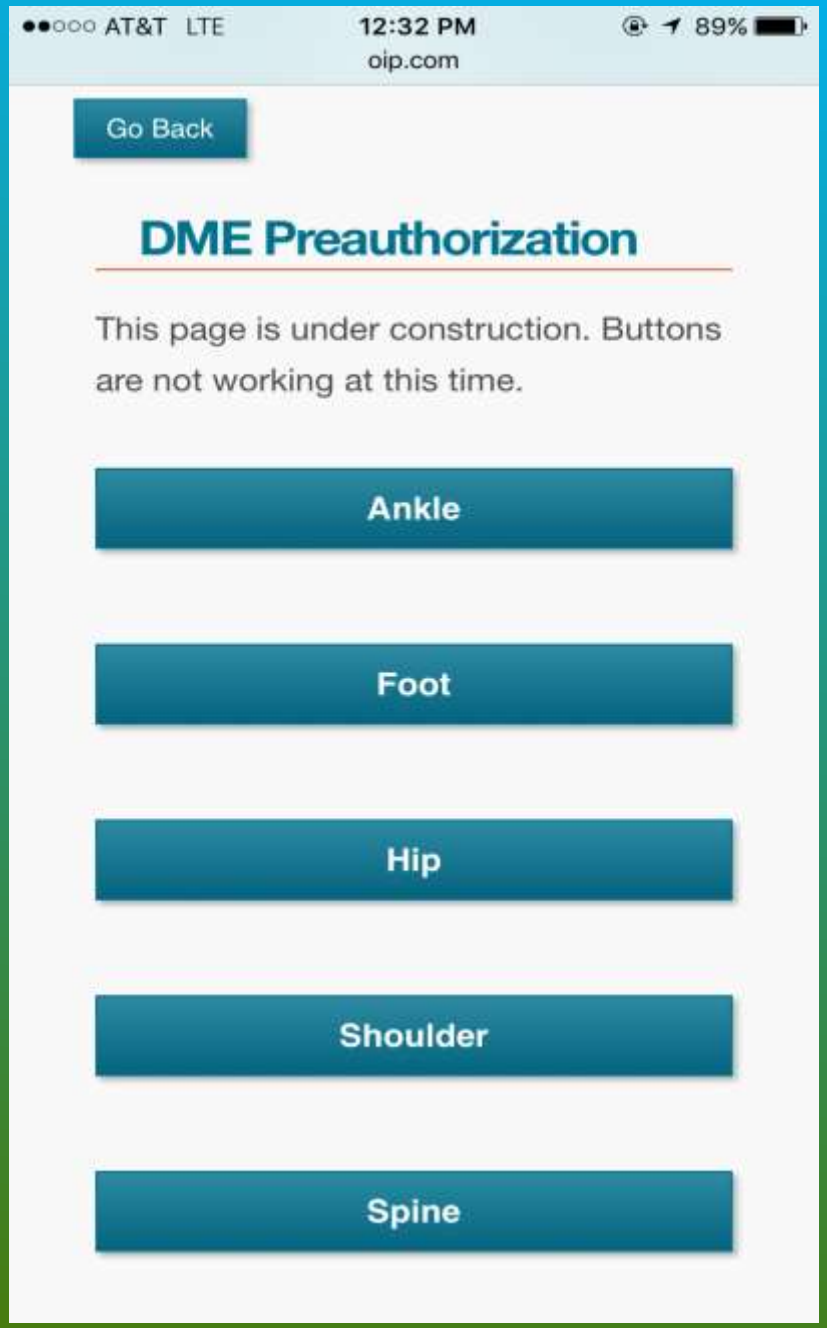

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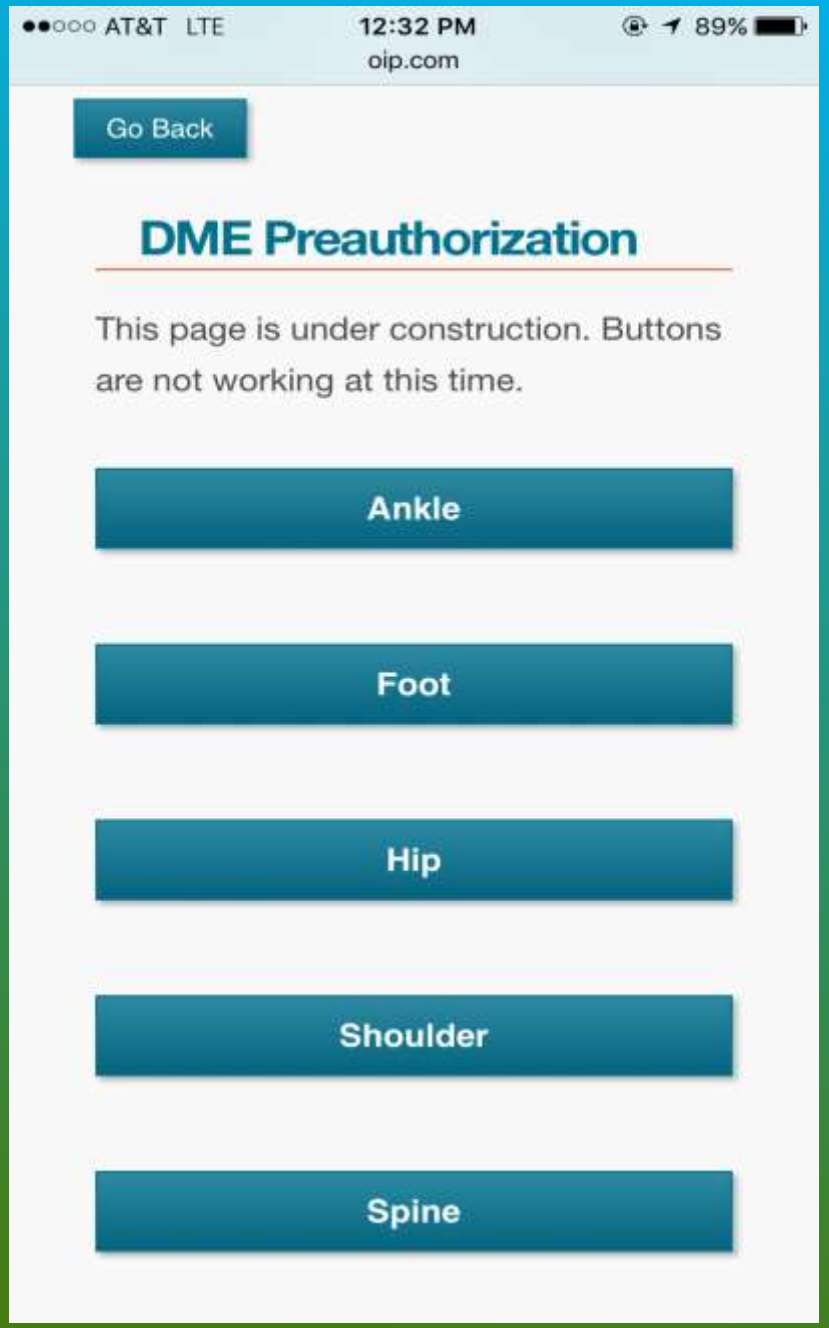
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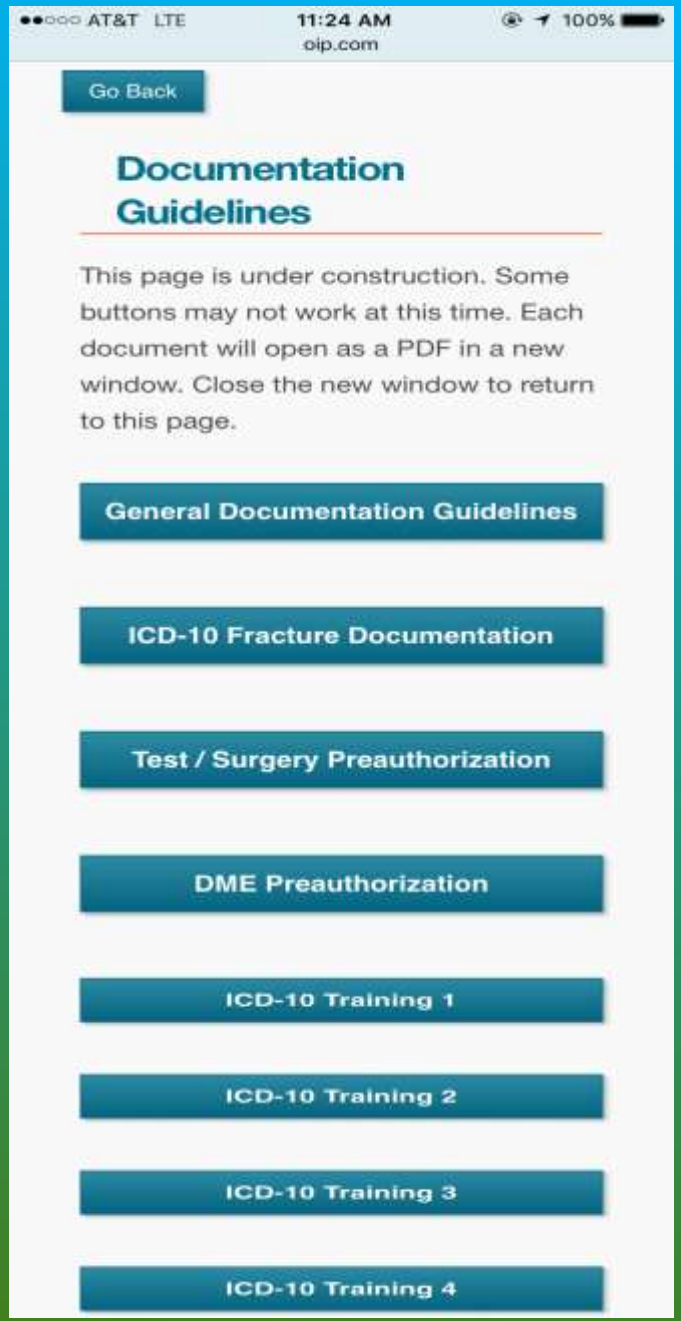
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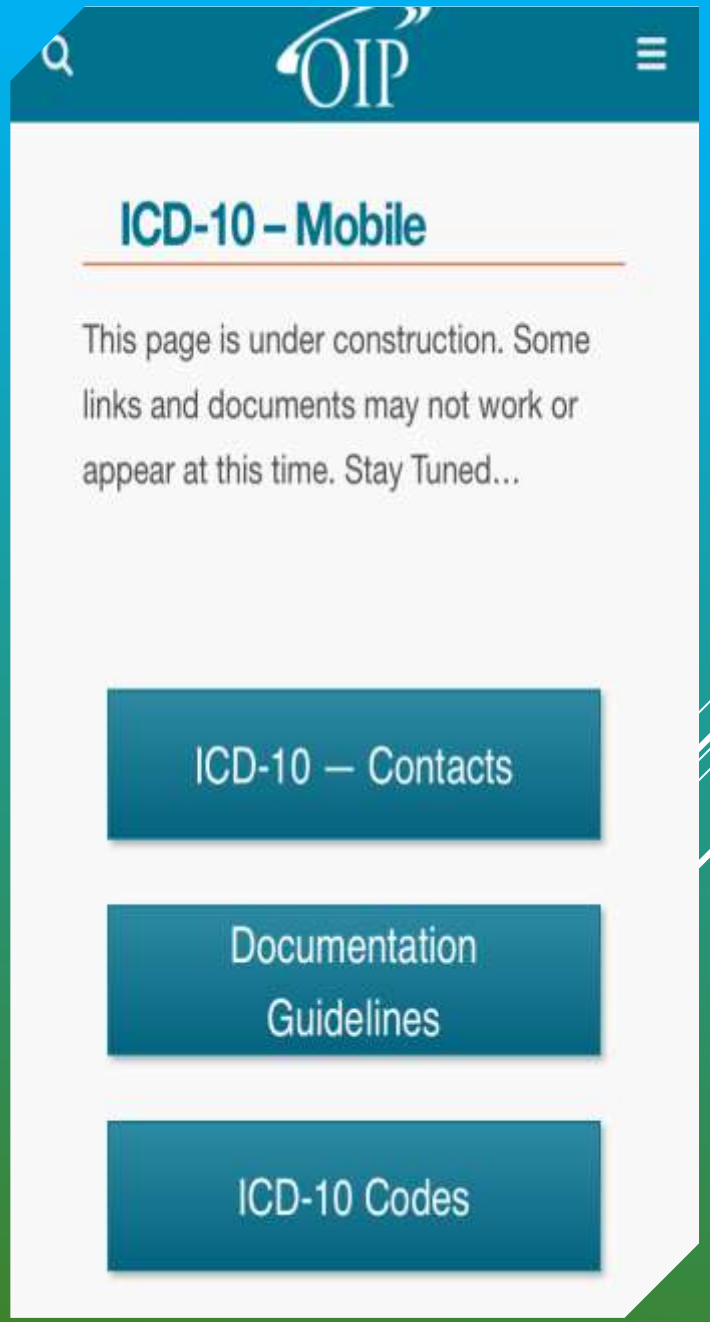
ICD-10 Training 3
ICD-10 Training 4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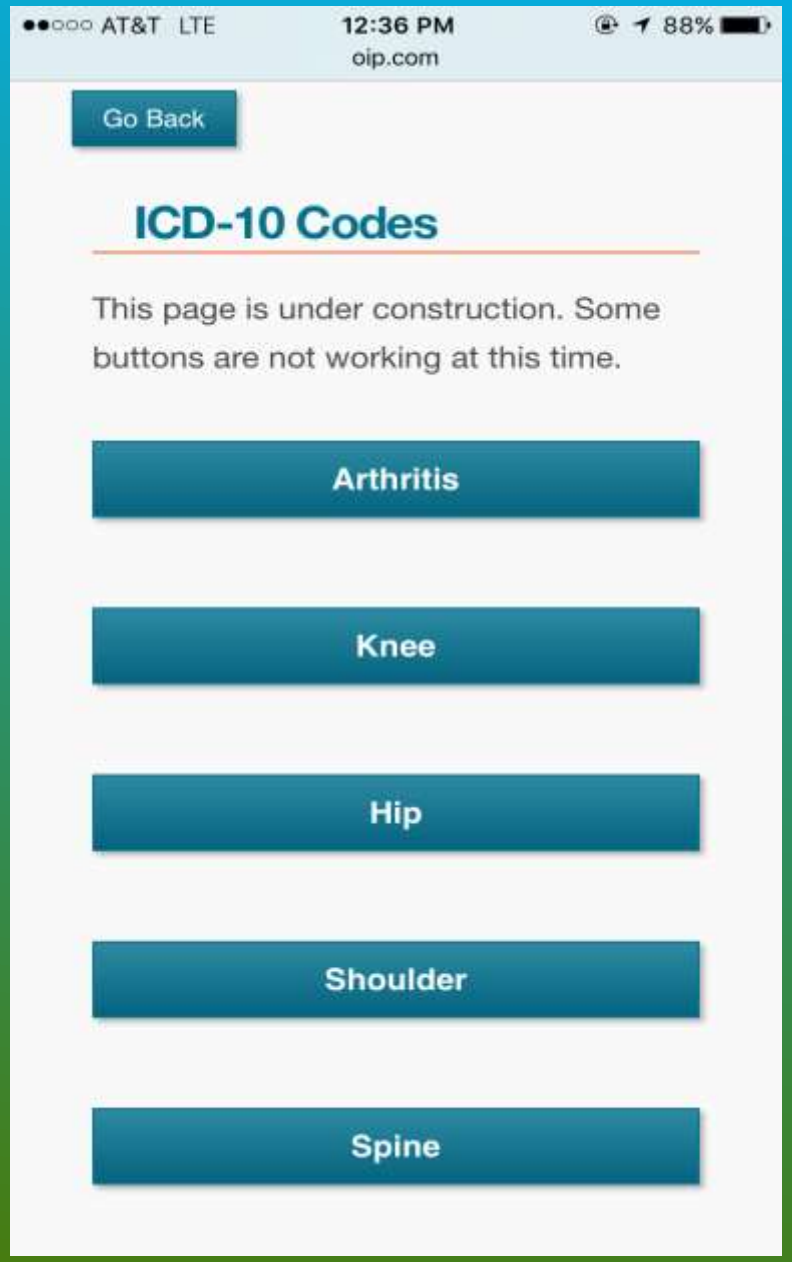

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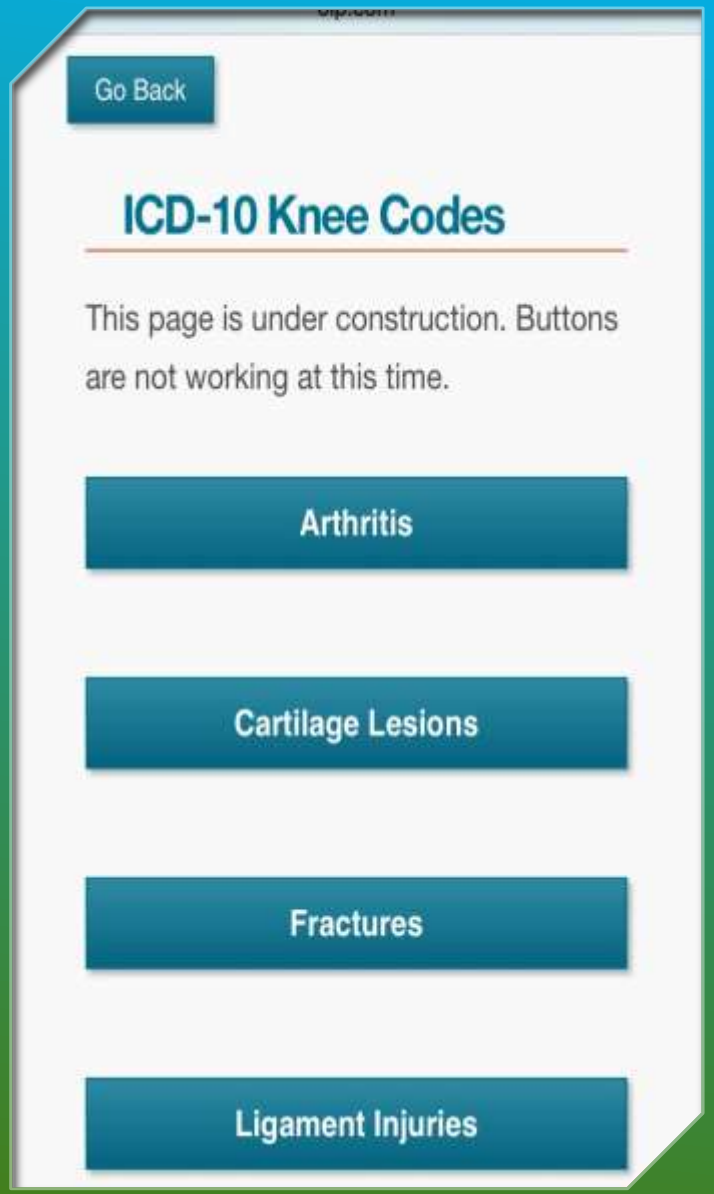

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Example of embedded ICD 10 coding information