Clinical Documentation Tips – *Orthopedics*

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).

### Fractures
- When documenting fractures, include the following parameters:
  1. **Type** – e.g. Open, closed, pathological, neoplastic disease, stress
  2. **Pattern** – e.g. Comminuted, oblique, segmental, spiral, transverse
  3. **Etiology** to document in the external cause codes
  4. **Encounter of care** – e.g. Initial, subsequent, sequelae
  5. **Healing status** if subsequent encounter – e.g. Normal healing, delayed healing, nonunion, malunion
  6. **Localization** – e.g. Shaft, head, neck, distal, proximal, styloid
  7. **Displacement** – e.g. Displaced, non-displaced
  8. **Classification** – e.g. Gustilo-Anderson, Salter-Harris
  9. **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.

### 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.

- ICD-10 provides more options for the coding osteoarthritis related encounters, including:
  1. Generalized forms of osteoarthritis or arthritis where multiple joints are involved.
  2. 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.

### 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:
  1. **Episode of Care** – e.g. Initial, subsequent, sequelae
  2. **Injury site** – Be specific as possible
  3. **Etiology** – How was the injury sustained (e.g. sports, motor vehicle crash, pedestrian, slip and fall, environmental exposure, etc.)
  4. **Place of Occurrence** – e.g. School, work, etc.

- Initial encounters may also require, where appropriate:
  1. **Intent** – e.g. Unintentional or accidental, self-harm, etc.
  2. **Status** – e.g. Civilian, military, etc.

Questions? Email us at MedicareRiskAdj@hmsa.com