



Orthopedics

Best Practice Documentation

Click on the desired Diagnoses link or press Enter to view all information.

Diagnoses:

- [Fractures](#) (Traumatic, Pathologic/Stress)
- [Osteoporosis](#)
- [Sprains/Strains](#)
- [Subluxation/Dislocation](#)
- [Episode of Care](#)
- [Osteoarthritis](#)
- [Osteonecrosis](#)
- [Osteomyelitis](#)
- [Surgical Procedures](#)
- [Key Documentation Concepts](#)

Contact the following for any documentation questions or concerns:

CDI: Shannon Menei 302-733-5973

HIMS Coding: Kim Seery 302-733-1113



Fractures

Best practice documentation for fracture diagnoses has many new key components to accurately reflect the severity of your patients injury.

- Type
 - Traumatic
 - Pathologic
- Location
 - Left, right , bilateral
 - Specific bone
 - Specific portion of the bone
- Acuity
 - Open
 - Closed
 - Displaced
 - Non-displaced
- Episode of Care
 - Initial
 - Subsequent
 - Sequela
- Healing status for subsequent encounters
 - With routine healing
 - With delayed healing
 - With non-union
 - With malunion
- Etiology
 - Place and Cause of Injury/Fracture
 - Underlying pathological cause
- Associated complications, such as:
 - Nerve injuries
 - DVT/PE
 - Acute blood loss/blood vessel injury
 - Hardware/Device related



Traumatic Fractures

Traumatic fractures also require:

- Classification
 - Gustilo-Anderson classification for open fractures of the long bones
 - Salter-Harris for physeal fracture
 - Modified Neer classification for fractures of the proximal humerus
 - For sacral fractures documentation of the type (I,2,3 or 4) and/or zone (I,II,III) where the fracture is located

- Fracture Pattern
 - Transverse
 - Oblique
 - Spiral
 - Comminuted
 - Segmental
 - Longitudinal
 - Greenstick



Pathologic & Stress Fractures

Pathologic or stress fractures require additional key elements for best practice documentation:

- Pathologic Fractures

- Etiology

- Osteoporosis
 - Neoplastic disease
 - Other (specify)

- Stress Fractures

- Also known as fatigue or march fractures
 - Identify external cause of the fracture



Osteoporosis

- Type
 - Age-related
 - Localized (Lequesne)
 - Other:
 - Drug-induced (specify drug)
 - Idiopathic
 - Disuse
 - Post oophorectomy
 - Post-surgical (specify)
 - Post-traumatic (specify)

- Document with or without pathological fracture



Orthopedic Documentation Examples

Insufficient Documentation

- 85 year old female with hx of osteoporosis presented with R hip pain. Reportedly slid from chair to floor. Xray shows fracture of right hip.
- 18 yr old male with hx of ORIF of malleolar fracture.

Best Practice Documentation

- 85 year old female with hx of osteoporosis presented with R hip pain. Reportedly slid from chair to floor. Xray shows fracture of right hip. **Will treat for pathologic right hip fx due to age-related osteoporosis.**
- 18 yr old male with hx of ORIF of malleolar fracture. Ortho consult confirms **nonunion** requiring revision.



Sprains/Strains

Sprains and Strains are delineated separately in the code set and when documenting should not be used interchangeably.

- Specify if Injury is:
 - ❑ Sprain (document the specific joint or ligament affected)
 - ❑ Strains (document the specific tendon or muscle affected)

- The episode of care should be documented and easily discernable through the documentation:
 - ❑ Initial encounter
 - ❑ Subsequent encounter
 - ❑ Sequela



Subluxation/Dislocation

- Subluxation - occurs when the joint only comes out of place partially and goes back into place naturally
 - Joint
 - Location within the joint
- Dislocation - a complete disruption of the joint
 - Joint
 - Location within the joint
 - If recurrent this should be specified
 - For acromioclavicular joint, specify the % of displacement
 - 100%-200%
 - Greater than 200%

The episode of care should be documented and be easily discernable through the documentation:

- Initial encounter
- Subsequent encounter
- Sequela



Sprain/Dislocation Documentation Examples

Insufficient Documentation

- Sprained ankle
- Dislocated shoulder

Best Practice Documentation

- Sprain of the **tibiofibular ligament of the right ankle.**
- Dislocation of the **right acromioclavicular joint, greater than 200% displacement.**



Episode of Care

The episode of care is a new concept in the coding of injuries, poisonings and certain other conditions in ICD-10.

It is indicated by the “7th” digit character of the diagnosis code. Physicians do not need to document the episode of care but it should be easily discernable via the documentation.

- Initial encounter:
 - Refers to every episode of care in which the patient is receiving active treatment for the injury, etc.
 - Emergency department (ED) visit—ED physician would report the diagnosis code S86.011A, Strain of right Achilles tendon, initial encounter.
 - If the patient is sent to radiology, the diagnosis code used for the radiographs is also S86.011A, Strain of right Achilles tendon, initial encounter.
 - Ankle is splinted; patient is given crutches and told to follow up with the orthopaedic surgeon. Patient sees the orthopaedic surgeon 3 days later. They discuss treatment options and plan surgery. Orthopaedic surgeon reports the office visit using S86.011A, Strain of right Achilles tendon, initial encounter.
 - Patient undergoes surgery later that week; the diagnosis used for the surgical procedure is still S86.011A, Strain of right Achilles tendon, initial encounter.
- Subsequent encounter
 - The encounter after the active phase of treatment and the patient is receiving routine care for the injury during the period of healing or recovery.
 - Example: Cast changes, suture removal
- Sequela
 - Used to indicate a complication or condition that arise as a direct result of an injury.
 - Example: Scar resulting from a burn



Osteoarthritis

- Involvement
 - Generalized
 - Localized
- Type
 - Primary
 - Secondary
 - Post-traumatic
- For localized
 - Specify site affected
 - Specify laterality

For Osteoarthritis of the Hip *also* note:

- Laterality
 - Bilateral
 - Unilateral (right or left)
- If known cause is from hip dysplasia document



Osteonecrosis/Avascular Necrosis

- Type or underlying cause
 - Idiopathic aseptic
 - Due to drugs (specify drug(s))
 - Due to previous trauma
 - Other secondary (specify)

- Exact anatomic location

- Laterality of bone affected



Osteonecrosis/Avascular Necrosis Documentation Examples

Insufficient Documentation

- Pt admitted for TKR.
- Avascular necrosis of the left hip. Patient has a history of femur fracture and repair.

Best Practice Documentation

- Pt admitted with **primary** osteoarthritis of the **right knee**, scheduled for TKR.
- **Osteonecrosis** of the **left femur due to previous traumatic fracture** .



Osteomyelitis

- Acuity
 - Acute
 - Subacute
 - Chronic
- Type
 - Acute
 - Hematogenous
 - Other - specify
- Chronic
 - Hematogenous
 - Multifocal
 - Other - specify
 - Specify if draining sinus is present
- Bone(s) affected
- Laterality
- Infectious organism/agent
- Underlying Cause (examples below include but are not limited to)
 - DM Foot Ulcer
 - DM Neuropathy
 - Chronic Pressure Ulcer



Osteomyelitis Documentation Example

Insufficient Documentation

Osteomyelitis of the left foot.
Secondary diagnosis - diabetes

Best Practice Documentation

Patient has diabetic foot ulcer of the left foot with exposed bone. **Acute osteomyelitis of the 1st metatarsal head of the left foot associated with underlying diabetic neuropathy.**



Surgical Procedure Documentation

External fixation devices:

Specify:

- Monopolar
- Ring
- Hybrid

Internal fixation devices:

Specify:

- If placement is intramedullary – there is a specific ICD-10 code for this

Hip/Knee Replacement:

Specify:

- Surface replaced
- Device used
- Cemented or uncemented

Shoulder Arthroplasty:

Specify:

- Device:
 - Synthetic substitute, reverse ball and socket
 - Synthetic
 - Autologous tissue substitute
 - Non autologous tissue substitute



Intraoperative and Postoperative Complications

The terms “**Post Op**” and “**Status Post**” are considered vague and require further clarification to determine if in fact the condition is a complication.

The key elements needed for best practice documentation include:

- The affected body system
- The specific condition
 - Accidental laceration (of specified organ)
 - Hematoma
 - Ileus
- Whether the condition is a/an:
 - Complication of care or due to the procedure
 - Expected procedural outcome
- When did the complication occur
 - Intraoperatively
 - Postoperatively



Hematoma due to a Procedure

- Site of the hematoma
 - Depth
 - Skin
 - Subcutaneous tissue
 - Musculoskeletal
- Procedure associated with the hematoma
 - The clinical significance of the hematoma
 - Considered a postoperative complication
 - Or an expected outcome
 - Unrelated to the procedure
 - Due to other chronic condition
 - Due to anticoagulants



Post-op Complication Documentation Example

Insufficient Documentation

Patient VQ scan positive for pulmonary embolism. Ultrasound positive for DVT of the right femoral vein. History of TKR two weeks ago.

Best Practice Documentation

Postop pulmonary embolism and right femoral DVT **most likely resulting from immobility from recent TKR.**



Key Documentation Concepts for Orthopedics

- Specify *exact* anatomical site affected
- Document etiology and manifestations
- Specify acuity
- Specify the healing status
- Document any associated infection and organism
- Provide information about the encounter type (initial, subsequent, sequela)



Take the Extra Step!

For further specificity of individual systems, please refer to specialty module dedicated to that system.

Document:

- ALL chronic conditions – present and stable but managed.
- Significance of abnormal tests. (i.e. UTI, electrolytes, echo)
- Clarify whether diagnoses are ruled in or ruled out.
- Establish cause-and-effect relationships. (i.e. PICC line infection)
- Laterality, if applicable.
- Explain the “why” and “because” to support medical necessity.
- Any tobacco use, abuse, dependence, history of smoke exposure. (e.g. second hand, occupational, etc.)