

Ferocious Fracture Documentation for ICD-10

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With less than 1 year to go before implementation of the International Classification of Diseases, 10th revision (ICD-10), the American Health Information Management Association (AHIMA) suggests that practitioners focus on their documentation to identify gaps that need filling before the “go live” date of Oct. 1, 2014. This article drills down on deficiencies that could prove problematic when reporting the diagnoses for traumatic fractures using ICD-10.

Faced with the challenge of making these documentation requirements manageable and memorable for orthopaedic practices, the clever cats at Karen Zupko & Associates felt the need to unleash their feline creativity. To tame traumatic fracture documentation and make the process eminently memorable, meet **LEO C. FAR**, king of the fracture documentation jungle.

Traumatic, not pathologic

ICD-10 differentiates traumatic fractures from pathologic fractures. Traumatic fractures are reported using the codes from ICD-10, Clinical Modifications (CM), Chapter 19, “Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88).

Important key documentation elements are required to support the correct ICD-10 diagnosis code and prevent the inappropriate use of codes labeled “unspecified.” That’s where the mnemonic LEO C. FAR comes in handy.

When a diagnosis of traumatic fracture is used, ICD-10 requires that the orthopaedic surgeon document the following:

L Location and Laterality

Documentation must include both the name of the bone and the specific location of the fracture on the bone. In addition, when appropriate, the documentation must identify the fracture as being on the right or left side of the body.

E Encounter

The term “encounter” in ICD-10 is not the same as “visit” in Current Procedural Terminology (CPT) coding. A “visit” in CPT coding refers to the patient type (new or established). An

“encounter” in ICD references the treatment status. The choices for the type of encounter in ICD–10 are initial and subsequent.

Initial encounter codes are used for traumatic fractures when the patient is receiving active treatment. Surgical treatment, an emergency department encounter, and evaluation by a new physician are examples of active treatment that would require the use of an initial encounter code. Subsequent encounter codes are used after the patient has completed active treatment and is receiving care for the traumatic fracture during the recovery phase. For example, the subsequent encounter indicator would be used in the following situations:

- cast change or removal
- removal of external or internal fixation device
- medication adjustment
- follow-up visits after fracture treatment

It is currently unclear whether the actual words “initial encounter” or “subsequent encounter” will be required as part of the documentation. For example, a statement about “taking the patient to the operating room” should be sufficient to indicate “initial encounter,” while a statement to “follow-up with routine healing” should be sufficient to support the use of the “subsequent encounter” codes. However, this particular documentation requirement has not yet been clarified.

O Open or Closed

Documentation must include a statement describing the fracture as open or closed.

C Classification, Category, or Cause

This documentation element indicates different things depending on the location and type of fracture. An open traumatic fracture of a long bone, for example, would require that the documentation include the Gustilo classification of the fracture. Documentation for a physal fracture must include the correct Salter-Harris classification. A modified Neer classification is used to describe certain fractures of the proximal humerus, and pelvic fractures require documentation of the zone where the fracture is located.

F Fracture pattern

ICD–10 also requires that documentation include the fracture pattern, as well as the fracture location. Terms such as transverse, oblique, spiral, comminuted, segmental, longitudinal, and greenstick are used to describe fracture patterns at different locations.

A Alignment

ICD–10 requires that the documentation note the alignment of the bones. Is the fracture displaced or nondisplaced?

R Result

Documentation of routine healing, delayed healing, malunion, or nonunion must be made at each encounter following the active phase of treatment.

If you start using "Leo's lingo" in documenting traumatic fractures now and use it consistently, you'll go a long way to ensuring that your documentation will support the proper ICD-10 diagnosis code in 2014.

AHIMA also suggests that a focused effort to become proficient in ICD-10 coding should begin 6 to 9 months before the implementation. Sharpen your documentation and stay tuned for more on ICD-10 coding and transition efforts.

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Image

[LEO C. FAR](#)

AAOS *Now*

November 2013 Issue

<http://www.aaos.org/news/aaosnow/nov13/managing7.asp>

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