Understanding Coding of Fractures, Joint Replacements and their Complications

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Objectives

1. Accurately code trauma and pathological fractures and their complications
2. Code internal fixation device problems
3. Understand the sequencing for coding the sequelae of fractures
4. Master coding joint explantations and joint replacements
5. Understand the correct coding for the complications of joints
6. Learn what constitutes a periprosthetic fracture
7. When to assign the correct seventh character A vs D
Fractures

Traumatic, Pathological, Stress
Fractures

• Found in Chapter 19: Injury, poisoning, and certain other consequences of external causes (S00 – T88)

• From the Guidelines:
  – Most categories in this chapter have three 7th character values: A, initial encounter; D, subsequent encounter; and S, sequela.
    • Categories for traumatic fractures have additional 7th character values.
    • As always, while the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.
Fractures

• 2 Types:
  – Traumatic
  – Pathological

• All *injuries* are grouped together in Chapter 19 by anatomical location and then by type of injury, within that location, with traumatic fractures integrated by location.
Traumatic Fractures

- Fracture coding requires documentation of:
  - Site;
  - Laterality;
  - Type of fracture;
  - Whether it is displaced or not displaced;
  - The encounter – initial, subsequent, or sequela; and
  - The stage of healing.

- The fracture is coded with the appropriate 7th character.
- Aftercare Z codes should not be used to indicate aftercare for traumatic fractures.
  - For “aftercare of a traumatic fracture”, assign the acute fracture code with the appropriate 7th character.
7th Characters for Traumatic Fractures

- The 7th character identifies:
  - Fracture type;
  - Whether healing is routine, delayed, malunion; and
  - Encounter type
- initial encounter (A, B, C) is used for each encounter where the patient is receiving active treatment for the fracture.
  - The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion.
Subsequent Encounter for Fractures

**Subsequent care:** for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase.
Open Fracture Guidance

- Open fracture designations are based on the Gustilo open fracture classification:
  - Grade I, Grade II, Grade IIIA, IIIB, IIIC
  - For fractures of the forearm, femur, and lower leg, including ankle.
- When a Gustilo classification type is not specified for an open fracture, the 7th character for open fracture type I or II should be assigned:
  - B, E, H, M, or Q
# Gustilo Open Fracture Classification

<table>
<thead>
<tr>
<th>Gustilo Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Open fracture, clean wound, wound &lt;1 cm in length</td>
</tr>
<tr>
<td>II</td>
<td>Open fracture, wound &gt; 1 cm but &lt; 10 cm in length without extensive soft-tissue damage, flaps, avulsions</td>
</tr>
<tr>
<td>IIIA</td>
<td>Open fracture with adequate soft tissue coverage of a fractured bone despite extensive soft tissue laceration or flaps, or high-energy trauma (gunshot and farm injuries) regardless of the size of the wound</td>
</tr>
<tr>
<td>IIIB</td>
<td>Open fracture with extensive soft-tissue loss and periosteal stripping and bone damage. Usually associated with massive contamination. Will often need further soft-tissue coverage procedure (i.e. free or rotational flap)</td>
</tr>
<tr>
<td>IIIC</td>
<td>Open fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury.</td>
</tr>
</tbody>
</table>
Traumatic Fractures

• Displaced vs. Non-displaced
  — A fracture not specified as displaced or non-displaced is always coded to displaced
    • If the code option is available. Not all fracture codes have an option for displaced.
    — Displaced: 2 ends of the bone are separated from each other
    — Non-displaced: Bone remains aligned

• A fracture not indicated as open or closed should be coded to closed.

• Therefore, the default is closed, displaced.
Traumatic Fractures Coding Summary

• Multiple fractures are coded individually and sequenced according to the severity of the fracture.

• Do not code the wound additionally when the bone breaks through the skin in an open fracture.

• Complications of fractures should be reported with the appropriate 7th character for:
  ➢ Delayed healing;
  ➢ Malunion; or
  ➢ Nonunion.

*Code complication first!*
Sequela of Fracture

- Assign 7\textsuperscript{th} character “S,” sequela, for complications or conditions that arise as a direct result of a fracture.
- For example, patient with a right greater trochanter fracture due to falling out of bed refused a hip replacement. His fracture has healed, but his right leg is significantly shorter than his left.
  - M21.751, Unequal limb length (acquired), right femur
  - S72.111S, Displaced fracture of greater trochanter of right femur, sequela
  - W06.xxxS, Fall from bed, sequela

- Per the Conventions, the residual condition is coded first. Search the Index under the main term “Deformity” to find “unequal limb length.”
- The injury with 7\textsuperscript{th} character “S” is coded next.
- The 7\textsuperscript{th} character for the external cause, which is found in the Index to External Causes, should be the same as the injury code.
Orthopedic Aftercare Codes Z47.-

- Z47  Orthopedic aftercare
  - Z47.1  Aftercare following joint replacement surgery
  - Z47.2  Encounter for removal of internal fixation device *(Do NOT use!)*
  - Z47.3  Aftercare following explantation of joint prosthesis
  - Z47.81  Encounter for orthopedic aftercare following surgical amputation
  - Z47.82  Encounter for orthopedic aftercare following scoliosis surgery
  - Z47.89  Encounter for other orthopedic aftercare
    - Use for aftercare following surgery of musculoskeletal system
Internal Fixation Devices

- **Internal fixation**: A surgical procedure that stabilizes and joins the ends of fractured (broken) bones by mechanical devices such as metal plates, pins, rods, wires or screws.
  - ORIF: Open Reduction Internal Fixation: for repair of compound bone fractures/severe breaks. Bone is realigned using surgical techniques, hardware applied to stabilize the bone.
  - CRIF: Closed Reduction Internal Fixation: the reduction or setting of the fracture without surgery. There are no incisions. The surgeon manipulates the fracture into correct alignment with the use of traction. Once this is done, a splint or cast is applied to hold the reduction.

External Fixation Devices

- **External fixation**: a surgical treatment used to stabilize bone and soft tissues at a distance from the operative or injury focus. It provides unobstructed access to the relevant skeletal and soft tissue structures for their initial assessment and also for secondary interventions needed to restore bony continuity and a functional soft tissue cover.

[Image: commons.wikimedia.org/wiki/File:Ilizarov_on_right_leg.jpg]
Fracture Repairs

- When repaired by ORIF
  - Code acute fx code with appropriate 7th character
  - Should you code gait abnormality?
    - Not if it is integral to the condition
  - What if pins or other devices are present?
    - These may be surgical wounds captured for M1340 of OASIS
    - Z48.03, *Encounter for change or removal of drains* (if removing/pulling JP type drain)
    - Z48.01, *Encounter for change or removal of surgical dressing* (only if not complicated)
Coding Joint Replacements

• When the cause is **not** an injury, but a condition, such as osteoarthritis:
  • Assign Z47.1, *Aftercare following joint replacement surgery*
  • Routine care will be provided
  • The condition that caused the need for surgery is not coded, unless it is present in another location (e.g., OA of another joint).
  • The status code to identify the joint replaced (location and laterality) (Z96.6-) is also coded. (Z47.1 has a Use Additional Code note)

Patient admitted for surgical aftercare with right hip joint replacement due to bilateral hip OA. Patient has a stage 2 pressure ulcer on the right heel, determined to be the focus of care.

• M1021: L89.612, *Pressure ulcer of right heel, stage 2*
• M1023: Z47.1, *Aftercare following joint replacement surgery*
• M1023: M16.12, *Unilateral primary osteoarthritis left hip*
• M1023: Z96.641, *Presence of right artificial hip joint*
• M1023: Z48.01, *Attention to surgical dressings*
An aftercare code is *not* appropriate, per Q3 2016 Coding Clinic guidance:

- When the care is to treat a fracture
- When a patient is receiving another joint prosthesis after having one removed due to a still-resolving complication, such as a mechanical loosening,
- Rather, in these cases, assign the fracture code (*see Excludes 1 note at Z47*) or the code for the specific complication with the appropriate 7th character to indicate whether the patient is still receiving active treatment or not.
Fracture repaired by Joint Replacement

• Code the fracture code with seventh character ‘D’ for routine care
  – Should you code gait abnormality?
    • Not required if integral to the condition
  – MUST add Z96.6- code to identify the joint replaced
  – What if other devices are present?
    • These may be surgical wounds captured for M1340 of OASIS
    • Z48.03, *Encounter for change or removal of drains* (if removing/pulling JP type drain)
    – Z48.01, *Encounter for change or removal of surgical dressing* (only if not complicated)
Pathological Fractures

• Occur in bones that are weakened by disease, such as osteoporosis or cancer.
  – Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected.

• Spontaneous fractures are always pathological fractures.
  – If the record states compression fracture, inquire if there was significant trauma – this would instead be classified as an injury, not a pathological fracture. Clarify with the physician.

• All pathological fractures are classified according to their underlying cause:
  – M80.-, Osteoporosis with current pathological fracture
  – M84.4-, Pathological fracture, NEC
  – M84.5-, Pathological fracture in neoplastic disease
  – M84.6-, Pathological fracture in other disease
  – M84.7-, Nontraumatic fracture, NEC
Pathological Fractures

• Category M80.-, *Osteoporosis with current pathological fracture*, identifies the site of the fracture.

• Do not code “aftercare”

• Excludes 1: collapsed vertebra, pathological fracture, wedging of the vertebra

• Has a Use Additional Code to identify any major osseous defect prn

  – M80.0-, *Age-related osteoporosis with current pathological fracture*
    
    • *Involutional osteoporosis*
    • *Osteoporosis NOS*
    • *Postmenopausal osteoporosis*
    • *Senile osteoporosis*
Pathological Fractures

- M80.8-, Other osteoporosis with current pathological fracture
  - Drug-induced osteoporosis
  - Idiopathic osteoporosis
  - Osteoporosis of disuse
  - Postoophorectomy osteoporosis
  - Postsurgical malabsorption osteoporosis
  - Post-traumatic osteoporosis
Osteoporosis WITH Pathological Fracture

- Site codes under M80, Osteoporosis with current pathological fracture, are combination codes that identify the site of the fracture due to osteoporosis.
- A code from category M80 should be used when:
  - Patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.
    - Do not use a traumatic fracture code in this instance.

- Is it mandatory for a physician to absolutely state pathological fracture due to osteoporosis?
  - No, the diagnosis of fracture, in conjunction with the conditions of osteoporosis and a minor fall, is sufficient to code this as a pathological fracture due to osteoporosis.
So we know:

- Osteoporosis (*diagnosed*) + minor fall = Pathological fracture (*coder can make the link*)

What if the fall was indicated as a traumatic fall though by the H&P?

Patient sustained a fracture of the humeral shaft after slipping off a step in the garage. Patient also has osteoporosis. H&P stated it was a traumatic fracture.

- Query the physician to determine if the osteoporosis contributed to the fracture.
Osteoporosis with History of Fracture

- Category M81.-, *Osteoporosis without current pathological fracture*, is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past.

- For patients with a history of osteoporosis fracture(s), status code Z87.310, *Personal history of (healed) osteoporosis fracture*, should follow the code from M81.-.
Pathologic fracture due to a neoplasm

When an encounter is for a pathological fracture due to a neoplasm:

• And the **focus of treatment is the fracture:**
  – A code from subcategory M84.5-, *Pathological fracture in neoplastic disease*, should be sequenced first
  – “Code also” the neoplasm.

• And the **focus of treatment is the neoplasm** with an associated pathological fracture:
  – The neoplasm code should be sequenced first
  – Include the code M84.5- for the pathological fracture.
Stress Fractures

• Stress fracture is NOT a pathologic fracture
• Stress fractures are caused by repetitive force and may be caused by fragility - not a clear fracture, only tiny breaks in bone structure
• Bone is NORMAL and SUFFICIENT
  – Repeated stress to the area
  – Muscle surrounding area fatigues, cannot absorb repeated shock, transfers this to the bone
  – Tiny cracks occur due to repeated shock stress to area
  – Often due to overuse or excessively intense activity
  – >50% occur in lower leg, most often in foot
  – Initially test negative in an X-ray, takes days to weeks to show as a visible fracture line in a follow-up X-ray.
• Coded to category M84.3-, Stress fracture
Periprosthetic Fracture

Periprosthetic Fracture

• A periprosthetic fracture is a broken bone that occurs around the implants of a total joint replacement or internal fixation device.

• If the prosthesis itself is broken:
  • Per Q4 2016 Coding Clinic guidance, if the prosthetic joint itself is fractured, then it is not a periprosthetic fracture
    • Is a complication of the implanted joint and should be captured with a code from T84.01- (Broken internal joint prosthesis) in Chapter 19.
Periprosthetic Fracture

• Codes for traumatic and pathologic fractures, as well as codes for periprosthetic fractures from the M97.- category, all require 7th characters, such as “D” for subsequent encounter or “S” for sequela.

• Code a periprosthetic fracture with the appropriate fracture codes, even after it has been surgically repaired.
Periprosthetic Fractures

• Determine if the patient’s periprosthetic fracture is traumatic or pathologic.

• Two codes are required to fully capture this condition when it is the focus of home health care:

  • Sequence the traumatic or pathologic fracture first
    • Such as with a code from S72.- category (Fracture of femur) or the M84.45-subcategory (Pathological fracture, femur and pelvis)
    • Then follow it with the periprosthetic fracture code from the M97.-, Periprosthetic fracture around internal prosthetic joint category.
Periprosthetic Fracture example

- A patient fell down the stairs, resulting in a displaced periprosthetic fracture of her right intertrochanteric femur near her right hip prosthesis, would be coded:
  - First with S72.141D (*Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing*); and
  - Then with M97.01xD (*Periprosthetic fracture around internal prosthetic right hip joint, subsequent encounter*).
Complications

Fractures, devices, joint replacements (and replaced again)
Joint Replacement Complications

- Reminder, joint replacement surgery involves removing part of an arthritic or damaged joint and replacing it with a prosthetic device.
- Common complications from this surgery include:
  - Dislocation of the prosthesis
  - Loosening of the prosthesis
  - Breakage or fracture of the prosthesis
  - Infection due to the prosthesis
- These situations would begin their coding in the T84.- category (*Complications of internal orthopedic prosthetic devices, implants and grafts*)
- Do **not** assign the Z96.6- code subcategory (*Presence of orthopedic joint implants*) if the joint is indicated by the complication code.
When a device goes bad, think **COMPLICATION**.

In the Alpha Index under **Complication**, roll down to the indent for **fixation device**, then find the type of complication you are seeking:
- Infection
- Mechanical issue
- Displacement
- Instability
- Dislocation, etc.
Internal Fixation Device Failure

Complications of devices

T84.-, Complications of internal orthopedic prosthetic devices, implants and grafts

- Code T84 includes all of the complications of orthopedic prostheses, implants and grafts.
  - Most of these codes indicate the joint affected so there is no need to add the Z96.6- code to indicate the prosthesis.
- Periprosthetic fractures are not considered complications.
- No “aftercare” code applies, including dressing changes, drain care, and suture removal.
  - Once the complication is repaired in the acute setting, continue to code the complication in home care and hospice with 7th character ‘D’ if healing/resolving.
Mechanical Complication of a joint

An aftercare code is **not** appropriate, per Q3 2016 Coding Clinic guidance:

- When a patient is receiving another joint prosthesis after having one removed due to a still-resolving complication, such as a mechanical loosening:
  - Code the specific complication with the appropriate 7\textsuperscript{th} character to indicate whether the patient is still receiving active treatment or not.

➢ Therapy-only admission for aftercare following revision of a loosened left knee joint prosthesis.
  - T84.033D, *Mechanical loosening of internal left knee prosthetic joint*
  - T84.023D, *Instability of internal left knee prosthesis*
  - Do we include Z96.652, *Presence of left artificial knee joint*?
Z47.3 Aftercare following explantation of joint prosthesis

• Clarifying terms:
  – Aftercare following explantation of joint prosthesis, staged procedure
  – Encounter for joint prosthesis insertion following prior explantation of joint prosthesis

• Definitions:
  – Staged procedure: any operation undertaken in two or more separate parts, with a lull between the two stages to facilitate tissue healing or clearance of infection.
  – Explantation: the removal of an implant; the act of transferring an explant.
Joint Explantation Clarification

• Use Z47.3, Aftercare following explantation of joint prosthesis:
  • *The complication has completely resolved*
  • *The entire joint has been removed*
  • *A new one has been inserted via a staged, planned procedure.*

➢ For example, patient had an infected joint which was totally removed, the infection is completely resolved, and a new joint has been inserted during a planned procedure at a later date.
Z47.3-, Aftercare following explantation of joint prosthesis

Coding Tips:

• Most instances for removal of an internal prosthesis are for complications or actual treatment of the fracture. If a mechanical complication has been repaired, continue to code the complication with a D until healed.

• This code is meant for a staged procedure and is appropriate for a new prosthesis once an infection has resolved. This code also includes an encounter for joint prosthesis insertion following the prior surgical removal of the joint prosthesis.

• If the joint prosthesis was removed and not replaced, code M96.89 provides additional information regarding instability of the joint, if documented.

  – **M96.89, Other intraoperative and postprocedural complications and disorders of the musculoskeletal system**

    • Clarifying terms: Instability of joint secondary to removal of joint prosthesis
Joint Explantation Summary

• Do NOT use Z47.3- when:
  • There is a mechanical complication, such as loosening of a joint. The complication remains until another joint is inserted.
    • Code the complication with the appropriate 7th character.

• Do NOT use Z47.3- when:
  • There is a joint revision (initial revision surgery).
    • Code the complication with the appropriate 7th character.

Assign Z89.-, Acquired absence of joint following explantation of joint prosthesis, with or without presence of antibiotic-impregnated cement spacer, until new joint is inserted. Then, Z96.6-, Presence of orthopedic joint implant, will be coded.
Joint Explantation Coding

- Therapy-only admission for aftercare following insertion of a new left knee joint prosthesis. The first prosthesis became infected and was removed 8 weeks ago. The infection was treated with antibiotics and is completely resolved. He also has osteoarthritis in his right knee, which he will have replaced in the near future.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1021a</td>
<td>Aftercare following explantation of knee joint prosthesis</td>
</tr>
<tr>
<td>M1023b</td>
<td>Unilateral primary osteoarthritis, right knee</td>
</tr>
<tr>
<td>M1023c</td>
<td>Presence of left artificial knee joint</td>
</tr>
</tbody>
</table>

- A new joint prosthesis was inserted via a staged procedure following removal of the previous one, and the complication is completely resolved. Therefore, coding Z47.33 is appropriate.
- Unilateral osteoarthritis defaults to primary.
- A new prosthesis was inserted, so presence of artificial joint is coded.
Complication: Infected Joint Prostheses

- Per the Decision Health Coding Companion, “Codes for postoperative infection are sometimes incorrectly assigned. Note that T81.4- has multiple Excludes 2 conditions listed that must be considered. An Excludes 2 condition indicates that the condition is “not included here.”
  - T81.4 Infection following a procedure
    - Excludes 2: infection due to prosthetic devices, implants and grafts (T82.6-T82.7, T83.5-T83.6, T84.5-T84.7, T85.7)
      - T82.6/7: Infection and inflammatory reaction due to cardiac valve prosthesis/Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts
      - T83.5/6: Infection and inflammatory reaction due to prosthetic device, implant and graft in urinary system/Infection and inflammatory reaction due to prosthetic device, implant and graft in genital tract
      - T84.5/7: Infection and inflammatory reaction due to internal joint prosthesis/Infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts
      - T85.7: Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts
Infected Joint Prostheses

- In the case of an infected joint prosthesis, T81.4- codes are less specific and should not be assigned for these conditions. Instead, assign the most specific, appropriate code from subcategory T84.5-, *Infection and inflammatory reaction due to internal joint prosthesis*.
  - For example: A patient with prior left hip replacement develops an infection in the prosthesis. Report code T84.52x-, *Infection and inflammatory reaction due to internal left hip prosthesis*.
  - It would not be correct to report T81.4-, *Infection following procedure*, as this code is less specific and does not indicate the specific infection.”
Other Complications

Complication(s) (from) (of) - continued
  intrauterine - continued
  contraceptive device - continued
  stenosis T83.85
  thrombosis T83.86
  procedure (fetal), to newborn P96.5
  jejunostomy (stoma) — see Complications,
  enterostomy
  joint prosthesis, internal T84.9
  breakage (fracture) T84.01-
  dislocation T84.02-
  fracture T84.01-
  infection or inflammation T84.50
  hip T84.5-
  knee T84.5-
  specified joint NEC T84.59

Coding Tip: If septic joint or septic arthritis is documented, use an additional code from M00.- to identify the organism.
Complications after Surgical Repair

- Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication code until it is healed.
- For a patient with an infected surgical incision being treated with an antibiotic following repair of a fracture, assign 2 codes – may have different 7th characters.
  - For example:
    - T81.42xA, *Infection following a procedure, deep incisional surgical site, initial encounter*
    - S72.002D, *Fracture of unspecified part of neck of left femur, routine healing*
- No aftercare code applies, including dressing changes, drain care, or suture removal.
Let’s work through these

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Femur Fracture</td>
<td>Infected Knee Prosthesis</td>
</tr>
<tr>
<td>Fracture with Osteoporosis</td>
<td>Infected Knee Prosthesis Final Step</td>
</tr>
<tr>
<td>Loose Knee Prosthesis</td>
<td>Fracture during Surgery</td>
</tr>
</tbody>
</table>
Femur Fracture

- Patient fell while rollerblading with his grandson, fracturing his femur. A week later, he had an ORIF performed. Home health is seeing him for incision care and functional mobility training.

So, what do we need to know?
- Focus of care: Fracture
- Is the focus related to, or due to, anything? Trauma
- Do we need further clarification from the physician or clinician for any diagnosis?
  The clinical notes clarified it as a supracondylar left femur fracture.
Coding Femur fracture

Patient fell while rollerblading with his grandson, fracturing his supracondylar left femur. A week later, he had an ORIF performed. Home health is seeing him for incision care and functional mobility training.

<table>
<thead>
<tr>
<th>Rationale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgically repaired fracture is still coded as a fracture, not with an aftercare code.</td>
</tr>
<tr>
<td>Should abnormal gait/difficulty walking be coded?</td>
</tr>
</tbody>
</table>

- **S72.452D, Displaced supracondylar fracture without intracondylar extension of lower end of left femur**
- **Z48.01, Encounter for change or removal of surgical wound dressing**
- **V00.111D, Fall from in-line roller-skates**
Fracture with Osteoporosis

- Patient fractured her ischium following an uncontrolled descent onto the hard commode seat. X-rays further revealed healed compression fractures at her sacrum. Due to the location, the physician determined she was not a surgical candidate. A scan indicated the presence of osteoporosis, and she was prescribed Fosamax. Nursing will instruct on medication and disease process, therapy will visit for functional mobility training and walker instruction.

So, what do we need to know?

- Focus of care:
  - Fracture
- Is the focus related to, or due to, anything?
  - Due to osteoporosis
- Do we need further clarification from the physician or clinician for any diagnosis?
  - The clinical notes clarified the right ischium was fractured.
- What are the appropriate comorbidities?
  - Osteoporosis
Coding Fracture with Osteoporosis

Patient fractured her right ischium following an uncontrolled descent onto the hard commode seat. X-rays further revealed healed compression fractures at her sacrum. Due to the location, the physician determined she was not a surgical candidate. A scan indicated the presence of osteoporosis, and she was prescribed Fosamax. Nursing will instruct on medication and disease process, therapy will visit for functional mobility training and walker instruction.

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-related osteoporosis with current pathological fracture, unspecified site, subsequent encounter for fracture with routine healing</td>
<td>M80.00XD</td>
</tr>
<tr>
<td>Unspecified fall, subsequent encounter</td>
<td>W19.XXXD</td>
</tr>
<tr>
<td>Personal history of (healed) osteoporosis fracture</td>
<td>Z87.310</td>
</tr>
<tr>
<td>Long term (current) use of bisphosphonates</td>
<td>Z79.83</td>
</tr>
</tbody>
</table>

Rationale:
- Category M80, Osteoporosis with current pathological fracture, is for patients who have a current pathologic fracture at the time of an encounter.
- Use M80.00X- for osteoporosis fractures of the rib and pelvis. It is the best choice until the classification can be updated.
The patient had a loosening of a 2014 left knee prosthesis. The prosthetic knee was removed and replaced with a new prosthesis.

So, what do we need to know?

- Focus of care: the knee prosthesis
  - Nursing will visit the patient for incision care and opiate monitoring.
  - Therapy will visit for functional mobility training.
- Is the focus related to, or due to, anything?
  - Loosening of a prior prosthesis
Coding Loose Knee Prosthesis

The patient had a loosening of a 2014 left knee prosthesis. The prosthetic knee was removed and replaced. Nursing will visit the patient for incision care and opiate monitoring. Therapy will visit for functional mobility training.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>T84.033D</td>
<td>Mechanical loosening of internal left knee prosthesis joint</td>
</tr>
<tr>
<td>T84.023D</td>
<td>Instability of internal left knee prosthesis</td>
</tr>
<tr>
<td>Z79.891</td>
<td>Long term (current) use of opiate analgesic</td>
</tr>
</tbody>
</table>

**Rationale:**

- Why do we code the complication and not an aftercare code? Coding Tips: *Once a complication is repaired in the acute setting, continue to code the complication in home care and hospice with 7th character D if healing/resolving. “... or when the patient is receiving another joint prosthetic after having one removed due to a still-resolving complication, such as a mechanical loosening, an aftercare code is not appropriate.”* (Q3 2016 Coding Clinic).
- Do we add the Z96.6- knee joint status code?
- Do we code for gait?
Infected Knee Prosthesis

- The patient has an infection of a new knee prosthesis. The prosthetic knee was removed, an antibiotic spacer was implanted, and the patient was sent home on IV antibiotics.

So, what do we need to know?

- Focus of care:
  - Infection of the knee

- Is the focus related to, or due to, anything?
  - The physician documentation noted the infection is MRSA, stated to be due to the prosthesis.

- Do we need further clarification from the physician or clinician for any diagnosis?
  - The clinical notes clarified the affected joint is the right knee.
  - Therapy will visit due to joint instability from the removal of the prosthesis.
## Coding Infected Knee Prosthesis

The patient has an infection of a new right knee prosthesis. The prosthetic knee was removed, an antibiotic spacer was implanted, and the patient was sent home on IV antibiotics for the MRSA infection.

### Rationale:
- This is a complication of a joint prosthesis, an infection to be exact. The T84.5- code is therefore used.

### Codes:
- **T84.53XA**, *Infection and inflammatory reaction due to internal right knee prosthesis, initial encounter*
- **M96.89**, *Other intraoperative and postprocedural complications and disorders of the musculoskeletal system*
- **B95.62**, *Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere*
- **Z89.521**, *Acquired absence of right knee*
- **Z45.2**, *Encounter for adjustment and management of vascular access device*
- **Z79.2**, *Long term (current) use of antibiotics*
The patient with the MRSA infection due to the knee prosthesis has returned to the hospital 6 weeks later for his final replacement. The antibiotic spacer and IV was removed, and a new right knee prosthesis was placed.

So, what do we need to know?

- Focus of care:
  - Aftercare
Coding Infected Knee Prosthesis Final Step

The patient with the MRSA infection due to the knee prosthesis has returned to the hospital 6 weeks later for his final replacement. The antibiotic spacer and IV was removed, and a new right knee prosthesis was placed.

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1021a</td>
<td>Z47.33</td>
</tr>
<tr>
<td>M1023</td>
<td>Z96.651</td>
</tr>
</tbody>
</table>

Rationale:
- The MRSA is no longer coded, as it is resolved.
- This is an explantation situation, as the:
  - The complication has completely resolved
  - The entire joint has been removed
  - A new one has been inserted via a staged, planned procedure.
Fracture during Surgery

Patient received a right THR for OA, sustained a fracture of the base of the right femoral neck during the surgery, was stated by the physician as a complication.

So, what do we need to know?

• Focus of care:
  Fracture

• Is the focus related to, or due to, anything?
  Due to the surgery. Not stated as periprosthetic.

• Do we use an aftercare code for the joint replacement or a T code?
Patient received a right THR for OA, sustained a fracture of the base of the right femoral neck during the surgery, was stated by the physician as a complication.

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>M1021a Displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing</td>
<td>S72.041D</td>
</tr>
<tr>
<td>M1023b Fracture of femur following insertion of orthopedic implant, joint prosthesis, or bone plate, right leg</td>
<td>M96.661</td>
</tr>
<tr>
<td>M1023 Presence of right artificial hip joint</td>
<td>Z96.641</td>
</tr>
</tbody>
</table>
In Summary…there are no Z codes for…

• There are no Z codes for:
  • Traumatic fractures
  • Pathological fractures
  • Aftercare of an injury
    • Assign the acute injury code with the appropriate 7\textsuperscript{th} character.
  • Aftercare indicating surgery on musculoskeletal system
    • Use code Z47.89, *Other orthopedic aftercare, NEC*
  • Encounter for rehab (therapy-only)
Thank you. Questions?

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In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section at the front of the program guide.