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Health Insurance for New Yorkers

Documentation and Coding: Rheumatoid Arthritis

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At Healthfirst, we are committed to helping providers accurately document and code their patients' health records. This tip sheet is intended to assist providers and coding staff with the documentation and ICD-10-CM selection on services submitted to Healthfirst specifically for rheumatoid arthritis. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Coverage decisions are based on the terms of the applicable evidence of coverage and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.

Seropositive (With Rheumatoid Factor)	
ICD-10-CM	**Description**
M05.*	Rheumatoid arthritis with rheumatoid factor

Seronegative (Without Rheumatoid Factor)	
ICD-10-CM	**Description**
M06.*	Other rheumatoid arthritis

Clinical Documentation Should Include:

- Updated status of condition (stable, improved, and/or worsening)
- Clear indication of the type of rheumatoid arthritis (seropositive, seronegative)
- Anatomical site(s) and laterality affected
- Any risk factors, i.e., smoking, obesity
- Documented details of any organ involvement
- If patient refuses medical treatment
- Use of terms such as "due to," "secondary to," or "associated with" to link associated conditions/manifestations of rheumatoid arthritis

Rheumatoid arthritis that is in remission:

- Must be described as "rheumatoid arthritis in remission"
- Should not be documented or described as "history of"
- Should not be documented only in the past medical history; rather, it should be included in the final impression/assessment

Diagnostic tools: Radiology, i.e., X-rays, rheumatologist evaluation, and lab/blood testing for inflammatory processes:

- Elevated erythrocyte sedimentation rate ("ESR" or "SED Rate")
- Rheumatoid factor or anti-cyclic citrullinated peptide (anti-CCP)

Treatment: Therapies, referrals, physical and occupational therapy, joint surgery, and medications such as:

- Disease-modifying anti-rheumatic drugs (DMARDs), anti-inflammatory agents
- Nonsteroidal anti-inflammatory drugs (NSAIDs), immunosuppressants, TNF-alpha inhibitors
- Glucocorticoids, only as adjuncts to therapy

*Requires an additional digit to complete the diagnosis code.

Documentation and Coding:

Rheumatoid Arthritis

Rheumatoid arthritis is an autoimmune disease that is also classified as a systemic disease because of the extensive changes it can make to different parts of the body. Ensure that all body systems affected by rheumatoid arthritis are documented.

RHEUMATOID ARTHRITIS AFFECTS MORE THAN JOINTS

Joint pain, swelling, bone damage in joints, and bone weakness

Finger/toe abnormalities, cold hands/ feet, numbness, ulcers, corns, and calluses

Dry eye, glaucoma, and dry mouth

Scarred lungs and lung nodules

Brain fog

Anemia, hardened arteries, and heart attacks

Kidneys and liver

DO NOT:

- Document rheumatoid arthritis as a confirmed condition if it is suspected and not truly confirmed. Rather, document signs and symptoms in the absence of a confirmed diagnosis.
- Describe rheumatoid arthritis as "history of" if the condition is still active (in diagnosis, "history of" implies a condition that no longer exists as a current problem).
- Use words that imply uncertainty ("likely," "probable," "apparently," "consistent with," etc.) to describe a current or confirmed diagnosis.

Coding Examples for Rheumatoid Arthritis

Coding Example 1:

Case	Follow-up - s/p penetrating keratoplasty, iritis OU (secondary). Has a medical history-allergies, sleep apnea, gastric bypass? ROS: Musculoskeletal negative; exam: all negative. A/P: s/p penetrating keratoplasty continue muro drops; rheumatoid arthritis.
ICD-10-CM Codes	Z94.7 - Corneal transplant status; M06.9 - Rheumatoid arthritis, unspecified
Rationale	Rheumatoid arthritis has insufficient supporting documentation, as it was only listed in the A/P. The documentation must show how the condition is being **M**onitored, **E**valuated, **A**ssessed, and **T**reated (**MEAT**).

Documentation and Coding:
Rheumatoid Arthritis

Coding Example 2:

Case	Here to review results of lab tests and X-rays ordered at last visit. **HPI**: Lab testing was performed last week. Patient also noticed pain in both hands, joints of fingers and wrists, and knees especially in the mornings—had difficulty getting dressed each morning. Currently taking Tylenol; relief lasted only two hours. **EXAM**: Bilateral finger joints and wrists swollen; and knees swollen warm and tender with good range of motion but no redness. **LABS**: Serology: Rheumatoid factor negative; **X-rays** of hands showed swelling of metacarpophalangeal and proximal interphalangeal joints; **X-rays** of bilateral knees showed swollen inflamed synovial membrane. Wrists are normal. A/P: Seronegative rheumatoid arthritis affecting both hands and knees. Start with methotrexate. Continue over-the-counter analgesics per label instructions. Return to see me in one month or sooner if symptoms worsen. Educational handouts given.
ICD-10-CM Codes	M06.041 - Rheumatoid arthritis without rheumatoid factor, right hand M06.042 - Rheumatoid arthritis without rheumatoid factor, left hand M06.061 - Rheumatoid arthritis without rheumatoid factor, right knee M06.062 - Rheumatoid arthritis without rheumatoid factor, left knee
Rationale	Provider documented and coded all body systems affected by rheumatoid arthritis

Coding Example 3:

Case	Patient is here for follow-up of results from elevated erythrocyte sedimentation rate ("ESR" or "sed rate") and rheumatoid factor or anti-cyclic citrullinated peptide (anti-CCP) for suspected rheumatoid arthritis. Currently not taking any meds. Hx: vitamin D deficiency, DM2. ROS: pain in both hands and feet, all other systems negative. Exam: musculoskeletal—normal. A/P: Consistent with rheumatoid arthritis.
ICD-10-CM Codes	M06.9 - Rheumatoid arthritis, unspecified
Rationale	ICD-10-CM Guidelines for Outpatient Services - "Do not code diagnoses documented as 'probable', 'suspected,' 'questionable,' 'rule out,' 'compatible with,' 'consistent with,' or 'working diagnosis' or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit."

Questions?

Please reach out to **#Risk_Adjustments_and_clinical_Documentation@healthfirst.org**.

For additional documentation and coding guidance, please visit the Coding section at **hfproviders.org**.

References: **ICD-10-CM Official Guidelines for Coding and Reporting FY 2021**; **CodingClinicAdvisor.com**; **Arthritis Foundation**; **AAPC.com**; **AHIMA.org**