

May 2019 | May is National Osteoporosis Month

FOCUS ON: Osteoporosis and fall and fracture risks

Half of all postmenopausal women will have an osteoporosis-related fracture during their lifetime; 25% of these women will develop a vertebral deformity, and 15% will experience a hip fracture. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality. Although hip fractures are less common in men than in women, more than one-third of men who experience a hip fracture die within 1 year.¹

The Bone Mass Measurement Act of 1998 broadened the selective screening by mandating Medicare coverage for densitometry services for individuals at risk of osteoporosis.²

Each year, 1 in 3 adults aged 65 or older falls; however, less than half mention the falls to their health care providers. Among older adults, falls are the leading cause of both fatal and nonfatal injuries, increasing the risk of early death. In 2010, 2.3 million non-fatal fall injuries among older adults were treated in emergency rooms, and more than 662,000 were hospitalized. The direct medical costs were \$31 billion. The average hospital cost for a fall is \$30,000 and increases with age.³ This major public health problem largely is preventable. Primary care providers should perform a fall-risk assessment.

To lower their hip fracture risk, older adults can:

- Get adequate calcium and vitamin D from food and/or from supplements
- Do weight-bearing exercises
- Get screened and, if needed, treated for osteoporosis

Primary and secondary hyperparathyroidism

Hyperparathyroidism places patients at increased risk for osteoporosis. Therefore, elderly patients with serum calcium >10.5 mg/dl could be considered to be screened for primary hyperparathyroidism. All patients with CKD stage III or higher should be screened for secondary hyperparathyroidism.

Documentation and coding tips

- When coding osteoporosis with a pathological fracture, select the code based on the site of the fracture, not the location of the osteoporosis
- Use adjectives that explain laterality and location to define the pathologic fractures with osteoporosis

Categories M80 and M81 are for osteoporosis with and without current pathological fracture. They include the following types of osteoporosis: age-related, idiopathic, drug-induced, senile, post-menopausal, localized, disuse, post-ophorectomy, post-surgical, post-traumatic, involuntal and NOS.

M80 is the category for osteoporosis with a current pathologic fracture at the time of encounter. A traumatic fracture code should not be used for any patient with known osteoporosis who suffers a fracture.

The appropriate 7th character is to be added to each code from category M80 to report episode of care and/or type of healing:

- **A** initial encounter for fracture: Active treatment for the fracture, including subsequent visits.
- **D** subsequent encounter for fracture with routine healing: Active treatment completed and in the healing and recovery phase.
- **G** subsequent encounter for fracture with delayed healing
- **K** subsequent encounter for fracture with nonunion
- **P** subsequent encounter for fracture with malunion
- **S** sequela

Example

Disuse osteoporosis with current fracture of right femur, initial encounter.

M80.851A Other osteoporosis with current pathological fracture, right femur, initial encounter

M81 is the category for osteoporosis without a current pathological fracture due to the osteoporosis, even if the patient has had a fracture in the past.

- If the patient has a documented history of a (healed) osteoporosis fracture, include the status code of Z87.310.
- Do not use a code from M81 if patient has osteoporosis with a current pathological fracture: Instead, use a code from category (M80).

Coding hyperparathyroidism

- E21.0** Primary hyperparathyroidism
- E21.1** Secondary hyperparathyroidism
- E21.2** Other hyperparathyroidism (tertiary)
- E21.3** Hyperparathyroidism, unspecified
- N25.81** Secondary hyperparathyroidism of renal origin

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2019: "A dash (-) at the end of an alphabetic index entry indicates that additional characters are required. Even if a dash is not included at the alphabetic index entry, it is necessary to refer to the tabular list to verify that no 7th character is required." The bolding of the ICD-10-CM codes represents categories, subcategories or codes that map to the CMS-HCC risk adjustment model for payment year 2019. Codes marked with a + directly after them represent new additions to the FY 2019 ICD-10-CM code classification.

This guidance is to be used for easy reference; however, the ICD-10-CM code book and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the "thought process" of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment, and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. Lastly, on April 2, 2018, the Centers for Medicare & Medicaid Services (CMS) announced that 2018 dates of service for the 2019 payment year model is based on 100% of the 2019 CMS-HCC model mappings released April 2, 2018. See: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>

Optum360 ICD-10-CM: Professional for Physicians 2019. Salt Lake City, UT: 2018.

1. Wright NC, Looker AC, Saag KG, et al. The Recent Prevalence of Osteoporosis and Low Bone Mass in the United States Based on Bone Mineral Density at the Femoral Neck or Lumbar Spine. Journal of Bone and Mineral Research. 2014;29(11):2520-2526. doi:10.1002/jbmr.2269.

2. Watt, NB. Understanding the Bone Mass Measurement Act. J Clin Densitom 2: 211-217, 1999.

3. Burns ER, Stevens JA, Lee R. The direct costs of fatal and non-fatal falls among older adults - United States. J Safety Res. 2016; 58:99-103. doi: 10.1016/j.jsr.2016.05.001.