Documentation and Coding Tips

Rheumatoid Arthritis

Rheumatology documentation and coding rules require very complex and specific details. Capture these essential elements to ensure accurate documentation and quality patient care for managing rheumatoid arthritis and your patient's comorbid conditions.

Specify When Documenting:

- **Type:** Adult onset (>16 years) or juvenile onset
  - If an adult patient has rheumatoid arthritis that originated in childhood, document juvenile rheumatoid arthritis. The age of onset determines whether the patient has rheumatoid arthritis or juvenile rheumatoid arthritis.
- **Anatomical site:** List specific joint(s) involved
  - For categories where no "multiple site" codes are provided, and more than one joint is involved, multiple codes should be used to represent the different sites involved
- **Laterality:** Left, right or bilateral
  - There is no available code to report bilateral rheumatoid arthritis of any joint. If the condition is bilateral, report two codes
- **Complications/manifestations:** Organ or system involvement, bursitis, myopathy, polyneuropathy, etc.
- **Symptoms:** Joint pain, swelling in joints, etc. in the absence of a confirmed diagnosis
- **Testing/treatment plan:** Blood test results, imaging results, medications, injections, joint replacement, referrals for rheumatology consultations and name of current rheumatologist, etc.
  - Document in the note the negative or positive results for rheumatoid factor
- **Immunosuppressant drugs:**
  - ICD-10-CM does not provide a specific code to identify long-term use of immunosuppressant drugs. Assign code Z79.899, other long-term (current) drug therapy, to report long-term use of immunosuppressant drugs.
  - Do not assign a code for an immunocompromised state caused by drug treatment of rheumatoid arthritis. Immunosuppressant drugs are commonly used in the treatment of autoimmune diseases such as rheumatoid arthritis for the specific purpose of suppressing the immune system.

Documentation and Coding Examples

Non-specific documentation example:

Patient presents today for follow-up of worsening rheumatoid arthritis.

Assign code: M06.9 Rheumatoid arthritis, unspecified.

Specific documentation example:

A 65-year-old patient has been complaining of stiffness and pain in her fingers in both hands first thing in the morning. Exam is performed, X-ray of the hands and rheumatoid factor blood test are ordered. The X-ray reveals the characteristics of early joint damage, and the rheumatoid factor is positive. She is diagnosed with rheumatoid arthritis.

Assign code: M05.841 Other rheumatoid arthritis with rheumatoid factor of right hand. M05.842 Other rheumatoid arthritis with rheumatoid factor of left hand.