Rheumatoid arthritis (RA) ICD-10-CM

Clinical overview

Definition and background

RA is a chronic, systemic inflammatory disorder that primarily affects the joints, causing pain, swelling and stiffness. It is an autoimmune disease in which the body's immune system attacks the body's own tissues. While the inflammatory response of rheumatoid arthritis affects primarily joints, it is a systemic inflammatory disorder that can also impact organs, such as the skin, eyes, heart, lungs and blood vessels. Rheumatoid arthritis usually begins after age 40, but it can occur at any age.

Causes

The exact cause of rheumatoid arthritis is not known. Some of the possible causes include:

- Genetic factors (inherited from parent to child)
- Environmental triggers
- Hormones (this disease is more common in women)

Signs and symptoms

Some people with this disease experience periods in which symptoms get worse (flares) or better (remissions). Others have a severe form of the disease that is active most of the time, lasts for many years or a lifetime and leads to serious joint damage and disability. Symptoms can include:

- Joint pain, warmth, redness and swelling
- Joint stiffness in the morning or after inactivity that can last for hours
- Fatigue
- Occasional fever
- Firm lumps (called rheumatoid nodules) that grow under the skin close to affected joints
- Loss of appetite and weight loss

Diagnostic tools

- Medical history and physical exam
- Evaluation by a rheumatologist (physician expert specially trained to diagnose, evaluate and treat rheumatic diseases)
- Joint X-rays
- Blood testing for inflammatory processes in the body or certain antibodies, for example:
  - Elevated erythrocyte sedimentation rate (also known as "ESR" or "sed rate") – indicates an inflammatory process
  - Rheumatoid factor or anti-cyclic citrullinated peptide (anti-CCP) – antibodies often found in patients with rheumatoid arthritis

Treatment

There is no cure for rheumatoid arthritis. The goal of treatment is to prevent joint damage, deformity and disability. With early and aggressive treatment, many patients can achieve long periods of time when inflammation is greatly reduced or absent with no active signs of disease (remission).

- **Drug therapy:** Many different types of drugs are used, often in combination. Examples:
  - **DMARDs** – relieve symptoms, slow disease progression and protect joints and other tissues from permanent damage. Examples: methotrexate, Plaquenil (hydroxychloroquine), Azulfidine (sulfasalazine), Arava (leflunomide), Minocin (minocycline)
  - **Immunosuppressants** – calm the immune system, which is attacking the body's own tissues. Examples: Imuran (azathioprine), Sandimmune (cyclosporine), Gengraf (cyclosporine)
  - **TNF-alpha inhibitors** – inhibit the action of tumor necrosis factor-alpha, which is an inflammatory substance produced by the body. Inhibiting this substance reduces the symptoms of rheumatoid arthritis. Examples: Enbrel (etanercept), Remicade (infliximab), Humira (adalimumab)
  - **Other drugs that target a variety of inflammatory processes** – Examples: Rituxan (rituximab), Orencia (abatacept), Kineret (anakinra)
- **Physical and occupational therapy**
- **Joint surgery** – if medications and conservative measures fail to prevent or slow joint damage.

The appropriate use of therapies is based on general principles that have been widely accepted by major working groups and by professional organizations of rheumatologists. These principles include:

1. Early recognition and diagnosis
2. Care by an expert in the treatment of rheumatic diseases, such as a rheumatologist
3. Early use of disease-modifying antirheumatic drugs (DMARDs) for all patients diagnosed with rheumatoid arthritis
4. Importance of tight control with target of remission or low disease activity
5. Use of anti-inflammatory agents, including nonsteroidal anti-inflammatory drugs (NSAIDs) and glucocorticoids, only as adjuncts to therapy

Clinical overview

Self-management strategies

- Regular exercise and physical activity when symptoms are controlled
- Rest when joints are inflamed, with gentle range of motion and stretching
- Application of heat or cold
- Skilled relaxation techniques
- Disease-specific patient education
- Complementary and alternative therapies, such as acupuncture, biofeedback, yoga and dietary supplements, such as plant or fish oils

Rheumatoid arthritis versus osteoarthritis – A comparison by WebMD

Rheumatoid arthritis and osteoarthritis are different types of arthritis. They share some characteristics, but each has different symptoms and requires different treatment; thus, an accurate diagnosis is important.

Osteoarthritis is the most common form of arthritis. Rheumatoid arthritis affects only about one-tenth as many people as osteoarthritis does. The main difference between osteoarthritis and rheumatoid arthritis is the cause behind the joint symptoms.

- Osteoarthritis is caused by mechanical wear and tear on joints.
- Rheumatoid arthritis is an autoimmune disease in which the immune system attacks the body's own joints.

	Rheumatoid arthritis	Osteoarthritis
Age of onset	May begin at any time in life	Usually begins later in life
Speed of onset	Relatively rapid, over weeks to months	Slow, over years
Joint symptoms	Pain, swelling, stiffness	Achiness and tenderness, but little or no swelling
Pattern of joints affected	Often affects small and large joints on both sides of the body (symmetrical), such as both hands, both wrists or elbows, or balls of both feet	Often begins on one side of the body and may spread to the other side. Symptoms begin gradually and are often limited to one set of joints, usually the finger joints closest to the fingernails or thumbs, large weight-bearing joints (hips, knees) or the spine.
Duration of morning stiffness	Longer than one hour	Less than one hour – returns at the end of the day or after periods of activity
Presence of symptoms affecting the whole body (systemic)	Frequent fatigue and a general feeling of being ill	Whole body symptoms are not present

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Documentation tips for physicians

Abbreviations

A good rule of thumb for any medical record is to limit – or avoid altogether – the use of acronyms and abbreviations. While "RA" is a commonly accepted medical abbreviation for rheumatoid arthritis, this abbreviation can have other meanings. The meaning of an abbreviation can sometimes be determined based on context, but this is not always true.

Best practice:

- The first mention in the office note of any medical diagnosis should be spelled out in full with the abbreviation in parentheses, i.e., "rheumatoid arthritis (RA)."
- Subsequent mention can be made using the abbreviation, except in the final assessment, where the diagnosis should again be documented in full.

Establishing the diagnosis

- When a patient reports a history of rheumatoid arthritis, the physician or other health care provider must validate this diagnosis through review of prior medical records, diagnostic test results and consulting specialist reports.
- Document details of diagnostic work-up and the outcome of current rheumatology specialist consultations. Include the name of the consulting rheumatologist.

Subjective

- In the subjective section of the office note, document any current symptom of rheumatoid arthritis reported by the patient (joint pain, swelling or stiffness; fatigue; episodes of fever; etc.).
- If there are no current symptoms, this section should show the patient was screened for symptoms.

Objective

In the objective section of the office note, document:

- Any current associated physical exam finding (such as joint deformity, etc.)
- Related laboratory or diagnostic imaging test results

Final assessment/impression

- Describe rheumatoid arthritis with the highest specificity (seropositive, seronegative, the particular joints affected, laterality, current status – active versus remission).

Final assessment/impression – continued

- Clearly link associated conditions or manifestations of rheumatoid arthritis by using linking terms such as "with," "due to," "secondary to" and "associated with."
- Do not document rheumatoid arthritis as a confirmed condition if it is only suspected and not truly confirmed. Rather, document signs and symptoms in the absence of a confirmed diagnosis.
- If rheumatoid arthritis is a confirmed diagnosis, do not describe it with terms that imply uncertainty (such as "apparently," "likely," "consistent with," "probable," etc.).
- Rheumatoid arthritis that is in remission but was taken into consideration by the physician or other health care provider when evaluating and treating the patient:
  - Should not be described as "history of." (In diagnosis coding, the phrase "history of" implies a past condition that no longer exists as a current problem.)
  - Should not be documented only in the past medical history; rather, it should be included in the final impression/assessment.
  - Should be described as "rheumatoid arthritis in remission."

Electronic medical record (EMR) reminder

- Some electronic medical records insert ICD-10-CM code descriptions into the medical record to represent the final diagnosis. For example, "MØ5.8Ø Other rheumatoid arthritis with rheumatoid factor of unspecified site."
- With these types of vague descriptions, the diagnosis will not be complete unless the physician clearly documents the "other" rheumatoid arthritis and "unspecified" site.

Note: ICD-10-CM is a statistical classification. It is not a substitute for a healthcare provider's final diagnostic statement. It is the provider's responsibility to provider legible, clear, concise and specific documentation of a final diagnosis, which is then translated to a code for reporting purposes. It is not appropriate for providers to simply list a code number or select a code number from a list of codes in place of a written final diagnosis.

Documentation tips for physicians

Treatment plan

Document a specific and concise treatment plan for RA.

DMARDs

The American College of Rheumatology advises that patients with an established diagnosis of rheumatoid arthritis should be treated with a DMARD, even in the first six months after the diagnosis, unless a contraindication, inactive disease or patient refusal is documented. Best documentation practices regarding DMARD therapy require the physician to document:

a) Specific details of current DMARD therapy in the treatment plan section of the record (not simply the medication list) with clear linkage of the medication to rheumatoid arthritis; or
b) Specific information describing any contraindication to DMARD therapy; or
c) A notation that rheumatoid arthritis is inactive; or
d) A statement of patient refusal of DMARD therapy and the reason for refusal.

ICD-10-CM tips and resources for coders

Coding rheumatoid arthritis

For accurate and specific diagnosis code assignment, the coder must:

- Review the entire medical record and note the exact rheumatoid arthritis description documented in the medical record; then, in accordance with ICD-10-CM official coding conventions and guidelines:
  a) Search the alphabetic index for that specific description.
  b) Verify the code in the tabular list, carefully following all instructional notes.

Rheumatoid arthritis and its associated disorders classify to the following categories:

- **MØ5** Rheumatoid arthritis with rheumatoid factor ***Excludes1*** rheumatic fever (IØØ); juvenile rheumatoid arthritis (MØ8.-); and rheumatoid arthritis of spine (M45.-)
- **MØ6** Other rheumatoid arthritis
  - Fourth, fifth and sixth characters are used with categories MØ5 and MØ6 to further specify the type of rheumatoid arthritis, as well as the particular site (joint affected) with laterality (left, right or unspecified).
- As noted in the documentation section, while RA is a commonly accepted medical abbreviation for rheumatoid arthritis, this abbreviation can have other meanings (e.g., refractory anemia, reactive arthritis, risk assessment). The meaning of an abbreviation can sometimes be determined based on context, but this is not always true. Use caution when coding RA – this abbreviation should not be coded as rheumatoid arthritis unless the individual medical record clearly shows RA is being used to represent rheumatoid arthritis.
- Severe joint pain is a characteristic of rheumatoid arthritis and is not coded separately from an already confirmed rheumatoid arthritis diagnosis.
- Do not code rheumatoid arthritis as a confirmed condition if it is documented as suspected and not truly confirmed. Rather, code the signs and symptoms in the absence of a confirmed diagnosis.

Rheumatoid arthritis in remission

RA documented as in remission is coded as current.

Seropositive versus seronegative rheumatoid arthritis

In most cases of rheumatoid arthritis, the patient's blood tests positive for rheumatoid factor and/or certain other antibodies (anti-CCP antibodies). These positive blood tests indicate the patient has seropositive rheumatoid arthritis, meaning the patient possesses the antibodies that cause an attack on joints and lead to inflammation.

- Seropositive rheumatoid arthritis codes to category MØ5 with fourth, fifth and sixth characters to provide further specificity, including site and laterality.

Patients can develop rheumatoid arthritis without the presence of these antibodies. This is referred to as seronegative rheumatoid arthritis. Seronegative patients are those who do not test positive for rheumatoid factor or anti-CCPs.

- Seronegative rheumatoid arthritis codes to category MØ6 with fourth, fifth and sixth characters to provide further specificity, including site and laterality.

Long-term (current) use of 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.

ICD-10-CM tips and resources for coders

Documentation and coding examples

Example 1	
Final diagnosis	Rheumatoid arthritis with polyneuropathy
ICD-10-CM code	**MØ5.5Ø** Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified site

Example 2	
Final diagnosis	Inflammatory myopathy related to rheumatoid arthritis
ICD-10-CM code	**MØ5.4Ø** Rheumatoid myopathy with rheumatoid arthritis of unspecified site

Example 3	
Final diagnosis	Rheumatoid arthritis of the spine
ICD-10-CM code	**M45.9** Ankylosing spondylitis of unspecified sites in spine
Comments	In the alphabetic index of the coding manual, arthritis>spine>rheumatoid instructs the reader to see Spondylitis, ankylosing.

Example 4	
Medical record documentation	Patient notes long history of "rheumatism" and joint pain.
Final diagnosis	Rheumatism
ICD-10-CM code	**M79.Ø** Rheumatism, unspecified
Comments	Rheumatism, unspecified, is a general term that describes diseases of muscle, tendon, nerve, joint or bone; symptoms include pain and stiffness.

Example 5	
Medical record documentation	82-year-old new patient presents with complaints of intermittent right knee pain. Someone once told him that he has "rheumatoid arthritis." Aspirin is used for pain when needed. He has never seen a rheumatologist and does not remember any lab testing. Joint exam: No upper extremity deformities. No joint effusion, warmth or reduced range of motion. Right knee with moderate crepitation on range of motion. Left knee normal. Otherwise lower extremity exam normal.
Final diagnosis	Primary osteoarthritis of the right knee
ICD-10-CM code	**M17.11** Unilateral primary osteoarthritis, right knee
Comments	Do not code rheumatoid arthritis as a confirmed condition from patient-reported information.

Example 6	
Medical record documentation	68-year-old female with history of hypertension, continues to follow up here for eosinophilia with myeloproliferative disorder. Currently not on any treatment. We are monitoring her with monthly CBCs. Has previously been on prednisone, but this caused her to be very short of breath so that has been discontinued. Complains of mild low back pain when first gets up in the morning BP 120/76. HR 80. RR 14. Temp 97.8. O2 saturation 97% on room air.
Final diagnosis	1. Eosinophilia and myeloproliferative disorder

ICD-10-CM tips and resources for coders

	2. HTN controlled 3. RA
ICD-10-CM codes	**D72.1** Eosinophilia **C94.6** Myelodysplastic disease, not classified **I1Ø** Essential (primary) hypertension
Comments	The meaning of abbreviation "RA" is not clear (could represent refractory anemia) and therefore cannot be coded. Physician query for written, dated and signed clarification is needed before coding "RA."

Example 7	
Chief complaint	"My hands and wrists still hurt, and I've lost my get up and go." Here to review results of lab tests and X-rays ordered at last visit.
History of present illness	Came to see me one week ago, reporting she was in good health until about six months ago when she started to feel tired and lethargic. She also noticed pain in both hands, joints of fingers and wrists, especially upon arising in the mornings – had difficulty cooking breakfast and getting dressed each morning. Also noticed pain was worse following her afternoon nap. Over-the-counter Tylenol or ibuprofen helped some, but relief lasted only two to three hours after each dose.
Physical exam	Bilateral finger joints and wrists swollen, warm and tender with good range of motion but no redness. Looks tired with flat affect.
Diagnostic imaging	X-ray of hands showed soft tissue swelling of the metacarpophalangeal and proximal interphalangeal joints. Symmetric joint space narrowing and subtle erosions of the right and left third and fourth metacarpophalangeal joints. Wrists normal.
Laboratory results	WBC 10.1; Hgb 10.6; Platelets 448 Sodium 137; Potassium 4.2; BUN 18; AST 35; Alk Phos 148; total protein 6.3; Calcium 8.9; TSH 2.53; ESR 55 Urinalysis 5-10 RBCs and 1+ protein. Serology: Rheumatoid factor 1:64; Anti-cyclic citrullinated peptides antibodies 1:128; ANA negative; C3 and C4 normal; Lyme IgM/IgG: negative. Synovial fluid: turbid, straw-colored; 40,000 WBC/mm3; 85% neutrophils; gram stain/culture negative; no crystals seen.
Final diagnosis	Early erosive, seropositive rheumatoid arthritis affecting both hands
Plan	Lab/X-ray results, diagnosis and treatment plan discussed. Educational handouts given. Therapy with methotrexate started, plus folic acid. Continue over-the-counter analgesics per label instructions. Return to see me in one month or sooner if symptoms worsen.
ICD-10-CM codes	**MØ5.741** Rheumatoid arthritis with rheumatoid factor of right hand without organ or systems involvement **MØ5.742** Rheumatoid arthritis with rheumatoid factor of left hand without organ or systems involvement

References: American College of Rheumatology; American Hospital Association Coding Clinic; Arthritis Foundation; ICD-10-CM Official Guidelines for Coding and Reporting; Mayo Clinic; National Center for Complementary and Alternative Medicine; National Institute of Arthritis and Musculoskeletal and Skin Diseases