

# Osteoporosis

Osteoporosis is characterized by low bone density and altered microstructure, significantly raising the risk of fragility fractures from minor activities. Often a "silent" disease, it's typically only detected after a fracture, as bones can break from simple actions like coughing. While anyone can be affected, risk increases with age, and it's more common in women. Early detection offers a good prognosis, but untreated cases can lead to chronic pain and serious complications like hip and spinal fractures. Screening is advised for women over 65 or with risk factors, primarily using DXA scans to measure bone mineral density. Treatment involves nutrition, lifestyle changes, exercise, fall prevention, and medications.

## Best Documentation Practices

Specify the type (Age related, diffuse, drug related, localized, postmenopausal).

Assess the risk factors (Age, family history, dietary history, lifestyle, fall history, medical conditions).

Document the presence of a pathological fracture and location (Femur, ilium, pelvis, vertebra).

Provide the status of the fracture (Routine, delayed healing, nonunion, malunion).

Interpret testing results; the patient's condition must be clearly articulated as non-clinicians cannot infer it.

Include a detailed treatment plan, noting any new, adjusted, or discontinued medications.



## M.E.A.T. the Condition

Proper documentation requires at least one of these four elements be present in the documentation for each condition.



**Monitor**

**How is the patient doing?**

Document signs, symptoms, disease progression/regression or ongoing surveillance



**Evaluate**

**What is the current state of the condition?**

Document current state, test results, medication effectiveness or response to treatment



**Address/Assess**

**How will the condition be evaluated?**

Document discussion, review of records, counseling, or ordering further tests



**Treatment**

**What is being done to help the condition?**

Document care, prescribed medications, referral to specialist or other modalities

CMS requires **annual coding and reporting of all chronic conditions**. A condition is not considered present in a given year unless it is appropriately documented and coded in that year.

# Osteoporosis ICD-10 Category Reference Guide

This list of ICD-10 codes (containing some incomplete codes) is not exhaustive. Refer to the current version of the ICD-10-CM Official Guidelines for Coding and Reporting, the ICD-10-CM Index to Diseases and Injuries, and the Tabular List of Diseases for a list of all ICD-10-CM codes and coding instructions. Copies of the Risk Adjustment models can be found at [www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/risk-adjustment](http://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/risk-adjustment).

## Disorders of bone density and structure: Osteoporosis

M80.0XXX	Age-related osteoporosis with current pathological fracture
M80.8XXX	Other osteoporosis with current pathological fracture
M81.0	Age-related osteoporosis without current pathological fracture
M81.6	Localized osteoporosis [Lequesne]
M81.8	Other osteoporosis without current pathological fracture

## Coding Example

**Documentation** **HPI:** 58-year-old female in today for f/u care of her fractured foot sustained in a fall last month. Seems to be healing nicely with no complaints and is looking forward to getting her cast off.  
**Medication List:** Reclast  
**Assessment & Plan:** Age-related Osteoporosis with current pathological fracture right foot with routine healing. Continue Reclast for bone health. Reviewed fall prevention and scheduled cast removal in 4 weeks.

**ICD-10 Code(s)** M80.071D Age-related osteoporosis with current pathological fracture, right ankle and foot subsequent encounter for fracture with routine healing

**Rationale** In the assessment & plan, the clinician specifically indicates the type of osteoporosis with presence of a current fracture to the right foot with routine healing. Treatment of the osteoporosis as well as fall prevention was addressed with the patient.

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NOTE: This tool is intended to assist with documentation only and not intended to take the place of clinical analysis. Information regarding any law or regulation does not constitute legal or tax advice and is subject to change based upon the issuance of new guidance and/or change in laws or regulations. Reference Official ICD-10-CM coding guidelines and manuals or electronic medical coding software for accurate ICD-10-CM codes and specificity.

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