AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Systemic Lupus Erythematosus Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Systemic lupus erythematosus (SLE) is a chronic, multisystem autoimmune disease driven by **immune-complex deposition, complement activation, and pathogenic autoantibody production** - particularly anti-double-stranded DNA **(anti-dsDNA)** and **anti-Smith antibodies**. These produce inflammatory injury across the kidneys, skin, joints, cardiovascular system, central nervous system, hematologic system, and lungs.[1] SLE is characterized by **heterogeneous** and often **nonspecific** presentations that **fluctuate during flares** and may mimic fibromyalgia, rheumatoid arthritis, and depression; consequently, a positive ANA alone never establishes the diagnosis. There are **no formal diagnostic criteria for SLE**. The diagnosis remains clinical, though the 2019 EULAR/ACR classification criteria are commonly used to support and standardize it.[2]

ICD-10 Codes:

SLE is classified under category **M32**. Idiopathic SLE subcodes include **M32.10** (organ involvement unspecified), **M32.11** (Libman-Sacks endocarditis), **M32.12** (pericarditis), **M32.13** (lung involvement), **M32.14** (glomerular disease/lupus nephritis), **M32.15** (tubulo-interstitial nephropathy), **M32.19** (other organ involvement), **M32.8** (other forms), and **M32.9** (unspecified). **M32.0** is drug-induced SLE and should not be applied to idiopathic disease. Cutaneous-only presentations — **L93.0** (discoid) and **L93.1** (subacute cutaneous) — should not be coded **M32** unless full SLE classification criteria are met. When lupus nephritis is present, **M32.14** should be paired with the applicable CKD subcode **N18.x** to fully capture renal involvement. Common comorbidities coded alongside **M32** include hypertension (**I10**), thrombocytopenia (**D69.6**), antiphospholipid syndrome (**D68.61**), and Sjögren syndrome with myopathy (**M35.03**); each should be coded separately when documented and clinically managed.

Prevalence and Burden: Approximately **204,000** individuals in the United States have SLE, including approximately **184,000 females and 20,000 males**.[3] SLE is roughly **9:1 female-to-male** in reproductive-age populations.[4] Incidence is **2-3 times** higher in Black, Hispanic, and Asian populations; SLE mortality in higher in non-Hispanic Black versus non-Hispanic White individuals, aOR **3.91**. Black, Hispanic, and Asian populations also carry 2-3 times higher incidence.[5] *For patients aged 65 and older, aOR SLE mortality is **3.20** (95% CI 3.10-3.31) compared with younger patients.*[5] **Late-onset SLE** (onset age 50 years or older) comprises approximately **20%** of all SLE case and presents with a distinct phenotype that complicates recognition.[6] Classic malar rash is less frequent **(53.5% vs. 66-76% in younger patients)**[6] and renal involvement is lower, while serositis (**29.6% vs. 11.4% in juvenile-onset)**, thrombotic events, cardiac involvement, and major depression occur more often.[6] Diagnostic delay is markedly longer - a mean of **45.3** months versus 28.1 months in early-onset disease ($p<0.001$) in the RELESSER registry ($n=3,619$) - and mortality is higher (**14.3% vs. 4.7%**, $p<0.001$), driven primarily by infections and comorbidities rather than disease activity itself. Cognitive impairment and brain fog are common and are frequently **misattributed** to age-related decline or dementia.

HCC/RAF V28 Mapping

ICD-10 CODE(S)[8]	HCC CATEGORY (V28)	RAF (CNA)	DOCUMENTATION REQUIREMENT
M32.10 (Systemic lupus erythematosus, organ or system involvement unspecified) **M32.11 (Libman-Sacks endocarditis)** **M32.12 (Pericarditis in systemic lupus erythematosus)** **M32.15 (Tubulo-interstitial nephropathy in systemic lupus erythematosus)** **M32.19 (Other organ or system involvement in systemic lupus erythematosus)** **M32.8 (Other forms of systemic lupus erythematosus)**	HCC 94 - Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders	**0.268**	Document active clinical management of idiopathic SLE at the encounter; specify the involved organ system explicitly to maintain clinical integrity. Disease-activity notation (e.g., SLEDAI-2K) supports medical necessity
M32.14(Glomerular disease in systemic lupus erythematosus (lupus nephritis))	HCC 94 - SLE and Other Specified Systemic Connective Tissue Disorders	**0.268**	**Lupus nephritis - the most underused specific code.** Document proteinuria/UPCR, biopsy class when available; pair with CKD stage code **(N18.x)** to document its independent CKD HCC
M32.13(Lung involvement in systemic lupus erythematosus)	HCC 280 (Fibrosis of Lung and Other Chronic Lung Disorders)	**0.319**	**Lung involvement** (pleuritis, pneumonitis, pulmonary hemorrhage, shrinking lung syndrome). Specify the manifestation and imaging findings
M32.0 (Drug-induced systemic lupus erythematosus)	No HCC in V28	-	**Drug-induced SLE maps to no HCC.** Document the causative drug, temporal relationship, and resolution after discontinuation. If autoimmune features persist off the drug and idiopathic SLE is established, recode to the appropriate M32.1x

ICD-10 CODE(S)[8]	HCC CATEGORY (V28)	RAF (CNA)	DOCUMENTATION REQUIREMENT
M32.9 (Systemic lupus erythematosus, unspecified)	**HCC 94**— Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders	0.268	**Avoid using when possible. Nationally overused code.** Organ involvement is frequently present but left undocumented—select a specific M32.x code whenever the clinical record supports it
L93.0 (Discoid lupus erythematosus)/ L93.1(Subacute cutaneous lupus erythematosus)	No SLE HCC	-	**Cutaneous-only lupus** (discoid; subacute cutaneous). Do not assign M32 unless 2019 EULAR/ACR classification criteria are met
M32.9(Systemic lupus erythematosus, unspecified)	HCC 94	**0.268**	**AVOID; Nationally overused.** Organ involvement is often present but undocumented - select the **specific M32.1x code** whenever the record supports it

ABBREVIATIONS: SLE = Systemic Lupus Erythematosus; HCC = Hierarchical Condition Category; ICD-10-CM = International Classification of Diseases, 10th Revision, Clinical Modification; RAF = Risk Adjustment Factor; CNA = Community Non-Dual Eligible, Aged; CMS = Centers for Medicare & Medicaid Services; CKD = Chronic Kidney Disease; UPCR = Urine Protein-to-Creatinine Ratio; SLEDAI = SLE Disease Activity Index. *Annual value is illustrative (RAF x representative base rate); actual MA plan payment varies by county

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

Risk-Adjusted Care Resources per Patient/Year

RAF weight × MA base rate = estimated annual care coordination support per documented HCC

SLE and Other Specified Systemic Connective Tissue Disorder

~$2,788

HCC 94 · RAF 0.268 · per active patient/year

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

2 RECOGNITION AND DIAGNOSIS

Medicare Screenings and Surveillance (Adult and Geriatric)

SERVICE/ SURVEILLANCE	FREQUENCY	CLINICAL PURPOSE	GERIATRIC NOTE
ANA (HEp-2 titer), anti-dsDNA, anti-Smith[2]	At diagnostic workup; anti-dsDNA every 3-6 months in known SLE[9]	**ANA at or above 1:80** is the obligatory entry criterion; anti-dsDNA correlates with activity and nephritis	Some late-onset patients are **anti-dsDNA** seronegative at diagnosis; serial values matter more than a single result[10]
Complement (C3, C4)[11]	Every 3-6 months stable; every 1-3 months if serologically active[9]	Falling complement with rising anti-dsDNA signals a serologic flare that may precede clinical flare	Attenuated serologic response possible in older adults; **pair with clinical assessment**
Urinalysis + urine protein-to-creatinine ratio (UPCR)[11]	Every 6 months minimum(ACR quality measure)[12]	Earliest, most sensitive indicator of lupus nephritis; only **39.5%** of patients nationally are adequately screened[13]	**GFR can fall substantially before creatinine rises**; do not rely on creatinine alone
CBC with differential; comprehensive metabolic panel[9]	Every 3-6 months stable; more often on immunosuppressants	Detect cytopenias and renal/hepatic effects of disease or therapy	**Lower marrow reserve** - cytopenias appear at lower doses and earlier
HCQ retinal screening (SD-OCT + fundus autofluorescence)[14]	Baseline; then annually after 5 years (low risk) or from initiation (high risk)	Detect parafoveal/ pericentral photoreceptor change before vision loss	Higher cumulative-exposure risk; CKD and age-related macular change raise risk - screen from initiation
DXA bone density; lipid panel; vaccinations (PCV20, influenza, recombinant zoster)[9]	DXA every 1-2 years on chronic steroids; lipids annually; vaccines per ACIP	Mitigate glucocorticoid osteoporosis, accelerated atherosclerosis, and infection risk	**Live vaccines contraindicated during immunosuppression**; recombinant zoster is the safe alternative

SERVICE/ SURVEILLANCE	FREQUENCY	CLINICAL PURPOSE	GERIATRIC NOTE

ABBREVIATIONS: ANA = Antinuclear Antibody; anti-dsDNA = Anti-double-stranded DNA; UPCR = Urine Protein-to-Creatinine Ratio; CBC = Complete Blood Count; HCQ = Hydroxychloroquine; SD-OCT = Spectral-Domain Optical Coherence Tomography; DXA = Dual-energy X-ray Absorptiometry; GFR = Glomerular Filtration Rate; CKD = Chronic Kidney Disease; ACIP = Advisory Committee on Immunization Practices; ACR = American College of Rheumatology

Subtle Early Signs in Older Adults (>65)

SUBTLE SIGN (>65)	WHY IT IS MISSED	ACTION
Arthralgia + fatigue + cytopenia, without malar rash[15]	**Malar rash is absent in nearly half of late-onset patients**, removing the classic visual cue	**Check ANA** when this combination is unexplained - malar rash is not required for SLE consideration
Cognitive impairment/brain fog[5]	**Misattributed** to age-related decline or early dementia	Consider neuropsychiatric SLE **(pooled prevalence ~52%)**;[1] screen cognition and review serology
Serositis - pleuritic chest pain, unexplained effusion[16]	More common in late-onset SLE **(29.6% vs. 11.4% juvenile)**[6] yet attributed to cardiac or infectious causes	Document pleuritis/pericarditis; obtain echocardiogram and inflammatory markers
Unexplained proteinuria or foamy urine[11]	Renal involvement is silent until advanced; creatinine often still normal	Obtain UPCR and urine microscopy; **UPCR >0.5 g/g warrants urgent rheumatology + nephrology referral**
New thrombotic event[5]	**Antiphospholipid antibodies** (present in 20-40% of patients) are **not** routinely checked in older adults	Assess antiphospholipid antibodies after unexplained venous or arterial thrombosis

ABBREVIATIONS: ANA = Antinuclear Antibody; SLE = Systemic Lupus Erythematosus; UPCR = Urine Protein-to-Creatinine Ratio

Geriatric Risk Factors

RISK FACTOR	RISK SIGNAL	NOTES
Age 65 years or older	Adjusted OR for SLE mortality **3.20** (95% CI 3.10-3.31) vs. younger patients[5]	**Higher infection-related mortality** and greater baseline comorbidity burden
Female sex	**~9:1 female-to-male** in younger patients[5]	**Sex ratio narrows with age**, so SLE should not be dismissed in older men

RISK FACTOR	RISK SIGNAL	NOTES
Black, Hispanic, or Asian ancestry	Incidence **2-3x** higher; AOR for SLE mortality **3.91** (95% CI 3.79-4.05) in non-Hispanic Black vs. White[5]	**Higher disease severity and organ involvement**; lower threshold for nephritis screening
Cardiovascular medications (hydralazine, procainamide)	**7-13% on hydralazine** and **15-20% on procainamide** develop drug-induced lupus; NAT2 slow acetylators carry markedly higher hydralazine risk[5,17]	Consider **drug-induced lupus** before idiopathic SLE - it is reversible
Crystalline silica exposure; current smoking[18]	**Strongest occupational association**; smoking shows a consistent positive association	Occupational and tobacco history are relevant even at diagnosis in later life

ABBREVIATIONS: SLE = Systemic Lupus Erythematosus; OR = Odds Ratio; AOR = Adjusted Odds Ratio; CI = Confidence Interval

Diagnostic Thresholds (2019 EULAR/ACR Weighted Criteria)

DIAGNOSTIC ELEMENT	THRESHOLD/PERFORMANCE	DOCUMENTATION
ANA (entry criterion)	Positive **ANA at or above 1:80** on HEp-2 cells is obligatory; **99.5%** sensitive but only 19.4% specific against non-SLE populations[5,19]	A negative ANA makes SLE very unlikely; a positive ANA alone is not diagnostic
ANA titer specificity	Specificity 74.7% at 1:80, rising to **96.6% at 1:320**[5,9]	**Record the titer**; higher titers carry greater diagnostic weight
2019 EULAR/ACR weighted scoring	Additive scoring across 7 clinical and 3 immunologic domains; classification at **10 or more points** with at least 1 clinical criterion[2]	Sensitivity **96.1%**, specificity **93.4%**; document the domains met[2]
Anti-dsDNA/anti-Smith (confirmatory)	**Anti-dsDNA ~57% sensitive, ~97% specific; anti-Smith ~24% sensitive, ~98% specific**[5]	**Anti-Smith strongly favors idiopathic SLE** over drug-induced lupus

ABBREVIATIONS: ANA = Antinuclear Antibody; anti-dsDNA = Anti-double-stranded DNA; EULAR = European Alliance of Associations for Rheumatology; ACR = American College of Rheumatology; SLE = Systemic Lupus Erythematosus

Clues to Dig Deeper

IF YOU SEE...	DIG DEEPER FOR...	NEXT STEP
Arthralgia attributed to fibromyalgia or osteoarthritis[15]	Constitutional symptoms + cytopenia + serositis suggesting SLE	**Order ANA**; if positive, obtain the confirmatory serologic panel
New-onset lupus after starting hydralazine, procainamide, or a TNF-alpha inhibitor[5]	Drug-induced lupus: antihistone antibodies present, anti-dsDNA/ anti-Smith typically absent, normal complement	**Discontinue the offending agent**; monitor for symptom resolution; refer to rheumatology if symptoms persist after discontinuation
Mild thrombocytopenia or leukopenia noted in passing[5]	Autoimmune cytopenia as an SLE manifestation rather than an incidental finding	**Order CBC with differential, ANA, anti-dsDNA, and complement levels**; refer to rheumatology for formal evaluation
Painless oral ulcers or non-scarring alopecia[2]	Mucocutaneous SLE activity that is frequently under-documented	**Describe the lesion and chronicity**; these contribute to classification scoring
Unexplained proteinuria on routine labs[11]	Subclinical lupus nephritis before creatinine rises	**Obtain UPCR and urine microscopy**; escalate per the urgent referral threshold

ABBREVIATIONS: ANA = Antinuclear Antibody; SLE = Systemic Lupus Erythematosus; anti-dsDNA = Anti-double-stranded DNA; TNF = Tumor Necrosis Factor; UPCR = Urine Protein-to-Creatinine Ratio

Common Oversights

COMMON OVERSIGHT	CONSEQUENCE	BETTER PRACTICE
ANA-positive, therefore lupus[5]	Overdiagnosis or premature labeling; **ANA** is **sensitive** but **not specific**	**Apply 2019 EULAR/ACR criteria**; confirm with SLE-specific antibodies before diagnosis
Failing to document specific organ involvement when present[2]	**Organ-specific monitoring**, treatment thresholds, and specialist co-management are missed	Assess and document **renal, cardiac, and pulmonary** involvement at **every encounter** — each system requires targeted monitoring and distinct management decisions
Deferring all HCQ management to rheumatology[5]	Care gaps during access delays; HCQ is within PCP scope	**Initiate HCQ** and coordinate the ophthalmology referral - do not wait for rheumatology

COMMON OVERSIGHT	CONSEQUENCE	BETTER PRACTICE
Treating SLE as a purely rheumatologic problem[20]	Cardiovascular risk underestimated; **untreated hypertension is common**	**Manage as an ASCVD** risk-equivalent with blood pressure, lipid, and glucose control

ABBREVIATIONS: ANA = Antinuclear Antibody; SLE = Systemic Lupus Erythematosus; HCQ = Hydroxychloroquine; PCP = Primary Care Physician; ASCVD = Atherosclerotic Cardiovascular Disease; HCC = Hierarchical Condition Category

Key Differentials in Elderly

DIFFERENTIAL	DISTINGUISHING FEATURE	PRACTICAL NOTE
Drug-induced lupus[5]	**Antihistone antibodies present; anti-dsDNA/anti-Smith absent**; complement normal; resolves on drug withdrawal	**Disproportionately** relevant in Medicare patients on cardiovascular agents
Rheumatoid arthritis[5]	**Erosive symmetric arthritis** with RF/anti-CCP; lacks the SLE multi-system serologic profile	**Overlap exists**; SLE arthritis is typically non-erosive
Fibromyalgia/depression[20]	Normal **inflammatory markers** and serology; no objective organ involvement	**Common misattribution** that delays SLE diagnosis by years
Infection in an immunosuppressed patient[4]	**Fever** with a localizing source; positive cultures; complement not typically consumed	**Distinguishing flare from infection** drives opposing treatment - contact rheumatology when uncertain
Sjogren syndrome overlap[21]	**Sicca symptoms** with anti-Ro/SSA and anti-La/SSB antibodies	More frequent in **late-onset SLE**; coordinate ophthalmologic and dental care

ABBREVIATIONS: SLE = Systemic Lupus Erythematosus; anti-dsDNA = Anti-double-stranded DNA; RF = Rheumatoid Factor; anti-CCP = Anti-cyclic Citrullinated Peptide; SSA/SSB = Sjogren-Syndrome-related Antigens A/B

Comorbidity Screening

COMORBIDITY	WHY IT MATTERS IN SLE	PRIMARY CARE ACTION
Cardiovascular disease	**SMR 2.25 for CVD death**; patients over 35 are more than 50x more likely to develop CVD than matched controls[5]	**Treat as an ASCVD** risk-equivalent; statin and blood pressure control regardless of Framingham score

COMORBIDITY	WHY IT MATTERS IN SLE	PRIMARY CARE ACTION
Lupus nephritis/CKD	**Nephritis** occurs in **~38%** overall and carries worse prognosis with age-related GFR decline[5]	**UPCR every 6 months**; dose-adjust renally cleared drugs; ACE inhibitor/ARB for proteinuria
Glucocorticoid-induced osteoporosis	Chronic steroids plus inflammation accelerate bone loss and fracture risk[22]	**DXA at baseline and every 1-2 years**; calcium + vitamin D; bisphosphonate per GIOP guidance
Infection	**Leading cause of death in late-onset SLE** (SMR 4.98, 95% CI 3.88-6.40)[5]	Keep PCV20, influenza, recombinant zoster, and COVID-19 vaccines current;[13] avoid live vaccines on immunosuppression
Depression/cognitive dysfunction	Major depression is prevalent in **late-onset SLE** and **drives non-adherence**[23]	**Annual PHQ-9** with documented follow-up; integrate behavioral health

ABBREVIATIONS: SLE = Systemic Lupus Erythematosus; SMR = Standardized Mortality Ratio; CVD = Cardiovascular Disease; ASCVD = Atherosclerotic Cardiovascular Disease; CKD = Chronic Kidney Disease; UPCR = Urine Protein-to-Creatinine Ratio; GFR = Glomerular Filtration Rate; ACE = Angiotensin-Converting Enzyme; ARB = Angiotensin Receptor Blocker; DXA = Dual-energy X-ray Absorptiometry; GIOP = Glucocorticoid-Induced Osteoporosis; CI = Confidence Interval

⚠ RED FLAG — EMERGENCY/ACTIVATE CRISIS RESPONSE

Same-day ED transfer or emergent specialist consultation for any of the following:

- **Diffuse alveolar hemorrhage** — hemoptysis, rapidly falling hemoglobin, bilateral infiltrates
  → Pulse IV methylprednisolone; consider plasmapheresis or IVIG; emergent rheumatology
  × Outcomes hinge on speed of recognition
- **Suspected TTP/TMA** — microangiopathic hemolytic anemia, thrombocytopenia, neurologic change, renal dysfunction
  → Initiate empiric plasma exchange immediately; do not wait for ADAMTS13 results
  × Mortality rises sharply with delay
- **Acute lupus myocarditis** — new heart failure, troponin elevation, ECG change
  → IV glucocorticoids plus immunosuppression; emergent cardiology and rheumatology
- **Mesenteric vasculitis** — acute abdomen with peritoneal signs
  → IV glucocorticoids; urgent surgical and rheumatology consultation
- **Severe neuropsychiatric lupus** — seizures, transverse myelitis, optic neuritis, acute confusional state
  → IV glucocorticoids plus immunosuppression; neurology consultation; MRI brain and spine
  × Myelitis deficits can become irreversible within 24–48 hours
- **Life-threatening cytopenias** — hemodynamic instability or active bleeding
  → Glucocorticoids plus IVIG and/or anti-CD20 therapy; hematology consultation

→ Activate emergency department and rheumatology on-call

RED FLAG — URGENT (24-72 HOURS)

- **New proteinuria >0.5 g/24h or active urine sediment** — hematuria or cellular casts
  → Urgent rheumatology and nephrology consultation; prepare for renal biopsy
  × Biopsy-guided class-specific treatment is required — empiric management is insufficient
- **Rapidly rising creatinine in known SLE**
  → Same-day nephrology contact; evaluate for proliferative nephritis (Class III/IV)
- **New severe thrombocytopenia** — platelets **<30,000/µL** without active bleeding
  → Same-day rheumatology or hematology evaluation
- **New psychosis or acute cognitive decline** attributed to SLE
  → Same-day rheumatology; rule out CNS infection before escalating immunosuppression
- **New visual symptoms on hydroxychloroquine**
  → Urgent ophthalmology referral; hold HCQ pending evaluation
- **Suspected flare vs. infection in an immunosuppressed patient**
  → Contact rheumatology before modifying immunosuppression
  × Escalating glucocorticoids in unrecognized infection is potentially life-threatening

AAVBC PERSPECTIVE

*AAVBC encourages primary care providers to approach **systemic lupus erythematosus as a multisystem disease with no single typical presentation**. SLE is a **clinical chameleon**, its symptoms mimic fibromyalgia, rheumatoid arthritis, and other autoimmune conditions, and can develop gradually over time in a pattern that does not immediately suggest a unifying diagnosis. SLE can manifest primarily as renal, cutaneous, musculoskeletal, or neuropsychiatric illness, and fatigue, joint pain, and cognitive changes are common early features that are often attributed to other causes, contributing to diagnostic delay.*

*In late-onset SLE, the clinical picture shifts further: renal involvement is less prominent, while serositis, myositis, pulmonary fibrosis, and Sjogren syndrome overlap are proportionally more common. **Cognitive impairment and brain fog in this population are frequently misattributed to age-related cognitive decline or dementia** rather than recognized as SLE manifestations. Major depression is also prevalent in late-onset SLE and contributes to medication non-adherence, functional decline, and increased healthcare utilization.*

***AAVBC supports early diagnostic consideration of SLE when persistent, unexplained multisystem symptoms are present, and encourages providers to move beyond a positive ANA as a standalone diagnostic endpoint.** A positive ANA requires follow-up documentation of specific clinical criteria and organ involvement. Without this, the diagnosis remains incomplete and the patient's clinical complexity is underrepresented. This helps ensure the right patients are identified, accurately characterized, and managed at the right time.*

3 MEAT DOCUMENTATION ESSENTIALS

Accurate documentation for SLE requires the clinical note to demonstrate **active engagement** with the condition **at each encounter**. SLE requires **annual re-documentation** with evidence of clinical management. A note that lists SLE as a problem without assessing disease activity or documenting treatment does not satisfy MEAT. **Organ system involvement** must be **explicitly stated**: defaulting to **M32.9** (unspecified) when renal, cardiac, or pulmonary involvement is present understates the clinical complexity of this multi-system disease.

Case vignette: A 72-year-old woman with SLE on hydroxychloroquine presents for follow-up with stable arthralgia and a UPCR of 0.3 g/g. The note reads only SLE, stable - continue meds. A coder cannot tell which organ systems are involved, whether the disease is active, or that renal monitoring occurred, so the encounter defaults to M32.9 and the clinical complexity is under-represented.

MONITOR: "Disease activity: SLEDAI-2K — arthralgia only, no new organ involvement. Weight: **68 kg**, stable. BP: **128/78**. Serologies: anti-dsDNA negative; **C3 98 mg/dL**, **C4 22 mg/dL** — complement within normal limits. UPCR: **0.3 g/g**, unchanged from last visit. CBC: WBC **5.2**, hemoglobin **12.8**, platelets **188K** — no cytopenias. HCQ retinal screening: ophthalmology completed **8 months ago**, no toxicity documented."

EVALUATE: "Serologic quiescence confirmed — stable complement and negative anti-dsDNA consistent with low disease activity. **UPCR 0.3 g/g stable; no evidence of active nephritis**. Arthralgia managed on current regimen; no new joint swelling or morning stiffness. HCQ dose **200 mg twice daily — 5.9 mg/kg/day** on actual body weight, within safe dosing range. No new mucocutaneous, cardiopulmonary, or neurologic symptoms reported."

ASSESS: "SLE, low disease activity. Primary active manifestation: musculoskeletal (arthralgia). Renal involvement stable — **UPCR 0.3 g/g, no hematuria or cellular casts**. SLE with glomerular involvement documented **(M32.14)**. HCQ retinal monitoring active; next ophthalmology due in **4 months**. No flare criteria met."

TREAT: "**HCQ 200 mg twice daily continued** — dose appropriate for actual body weight. UPCR repeat in **3 months**. Prednisone not currently indicated; low-dose steroid PRN plan discussed for flare. Vaccinations reviewed: pneumococcal and influenza up to date; zoster vaccine ordered today. Cardiovascular risk assessment: BP at goal; lipid panel ordered. Rheumatology co-management ongoing. Return in **3 months**; sooner if new symptoms."

Documentation Elements That Document SLE Complexity

- Whether SLE is idiopathic or drug-induced, with the causative drug named when relevant - **this single distinction determines whether the encounter maps**
- **The specific organ systems involved** (renal, cardiac, pulmonary, hematologic, neuropsychiatric), each tied to its **M32.1x** subcode
- **Disease activity at the encounter** - a SLEDAI-2K score or an explicit statement such as active malar rash or nephritic-range proteinuria
- **Chronicity and recurrence** (e.g., malar rash for 4 weeks; third flare this year) so the condition reads as ongoing rather than incidental

- **Hydroxychloroquine dose** with actual body weight and the date of the most recent retinal screening
- **Comorbidities being co-managed** - hypertension, dyslipidemia, CKD, osteoporosis - each coded to its own HCC where applicable

Reframing Common Documentation Shortcuts

SHORTCUT AS WRITTEN	WHY IT FALLS SHORT	REFRAMED DOCUMENTATION
"SLE, stable"	No organ system, activity, or management shown; defaults to **M32.9**	SLE with glomerular involvement **(M32.14)**, serologically quiescent; UPCR 0.3 g/g; continue hydroxychloroquine 300 mg daily
ANA positive, lupus	**ANA alone is not diagnostic** and does not support an HCC	SLE meeting **2019 EULAR/ACR criteria** (arthritis, low complement, anti-dsDNA positive); document domains met
Lupus, on plaquenil	Misses dose, body weight, and retinal-screening status the quality measure requires	SLE on hydroxychloroquine 5 mg/kg/day (actual body weight 70 kg); SD-OCT screening current
Drug-induced lupus (patient on hydralazine)	If autoimmune features persist off the drug, **M32.0** wrongly zeroes the HCC	If features resolve off hydralazine, **M32.0** is correct; if they persist, reclassify to idiopathic SLE **(M32.1x)**

ABBREVIATIONS: SLE = Systemic Lupus Erythematosus; ANA = Antinuclear Antibody; anti-dsDNA = Anti-double-stranded DNA; UPCR = Urine Protein-to-Creatinine Ratio; SD-OCT = Spectral-Domain Optical Coherence Tomography; HCC = Hierarchical Condition Category; EULAR = European Alliance of Associations for Rheumatology; ACR = American College of Rheumatology

DOCUMENTATION IS COMPREHENSIVE CODING

At each annual encounter, re-establish whether SLE is idiopathic or drug-induced, specify the organ systems involved, assess current disease activity, and document the management plan. Cytopenias, serositis, nephritis, and neuropsychiatric symptoms must be explicitly attributed to SLE in the assessment and plan to **support the transition from M32.9 (unspecified) to a diagnosis code that accurately reflects the patient's clinical complexity**.

4 TREATMENT AND REFERRAL QUICK GUIDE

Hydroxychloroquine is the foundation of SLE management for nearly all patients, it reduces flare frequency, organ damage accrual, and mortality, and should be continued indefinitely unless contraindicated. **Glucocorticoids** remain essential for acute disease control but carry **disproportionate risk in older adults**: infection, osteoporosis, cardiovascular events, and adrenal suppression accumulate with cumulative dose. The PCP's role is to **maintain the lowest effective steroid dose**, bridge to steroid-sparing agents early, and recognize the organ-specific thresholds that require immediate rheumatology or subspecialty escalation. The framework below follows the **2025 ACR guideline, 2023 EULAR recommendations, and 2024 KDIGO lupus nephritis guideline.**

Therapy Escalation Criteria

TREAT-TO-TARGET ELEMENT	THRESHOLD	ACTION
Treatment target[26]	Lupus Low Disease Activity State (LLDAS) at minimum; remission preferred	Aim for **SLEDAI-2K of 4 or lower** with prednisone at or below **7.5 mg/day** and no major-organ activity
Escalation trigger[27]	SLEDAI-2K increase of **2.6 points** = minimal clinically meaningful change; score of **3-4 = active disease**	Review and escalate therapy; assess for organ-threatening manifestations
Steroid target[24]	Maintenance prednisone at or below **5 mg/day**; taper to zero when possible	**Add a steroid-sparing agent** when the dose cannot be reduced below target
Hydroxychloroquine continuation[28]	**Continue indefinitely**, even during sustained remission	Discontinuation risk **outweighs benefit** in most patients; review before any dose reduction

ABBREVIATIONS: LLDAS = Lupus Low Disease Activity State; SLEDAI-2K = SLE Disease Activity Index 2000; PCP = Primary Care Physician

2025 ACR/2023 EULAR/2024 KDIGO-Aligned Treatment Escalation

STEP	AGENT(S)	ROLE/DOSE*	GERIATRIC MODIFICATION
1 - Foundation (all patients)	**Hydroxychloroquine**	At or below 5 mg/kg actual body weight/day (max 400 mg/day); associated with a **54% reduction in overall mortality** (pooled HR 0.46; 95% CI 0.38-0.57)[5]	**Baseline SD-OCT**; screen from initiation when CKD or age-related macular change is present
2 - Glucocorticoid bridge[24]	Prednisone; IV methylprednisolone for organ-threatening flares	Lowest effective oral dose, maintenance at or below **5 mg/day** (EULAR); IV pulse **250-1,000 mg/day x 3** days for severe disease	**Minimize duration**; start calcium + vitamin D and monitor glucose, BP, and bone density
3 - Steroid-sparing immunosuppression	**Methotrexate; azathioprine; mycophenolate mofetil**	**MTX** 7.5-25 mg/week; AZA 1.5-2.5 mg/kg/day **(check TPMT)**; **MMF** 1-3 g/day (2-3 g/day for nephritis per KDIGO)[11,25]	**Avoid MTX if eGFR <30**; reduce AZA/MMF in CKD; monitor CBC more frequently for lower marrow reserve
4 - Biologic escalation	**Belimumab; anifrolumab; voclosporin** (nephritis)	Belimumab IV 10 mg/kg q4wk or SC 200 mg/wk; anifrolumab IV 300 mg q4wk; voclosporin 23.7 mg BID with MMF **(eGFR >45)**[5]	**No fixed geriatric dose change**, but infection risk rises with age; voclosporin needs close BP/renal monitoring
5 - Organ-threatening/ refractory	**Cyclophosphamide; rituximab** (off-label)	CYC IV pulse 500 mg q2wk x 6 doses (Euro-Lupus) for severe nephritis; rituximab 1,000 mg IV x 2 doses for refractory disease[25,29]	**Reserve CYC for truly organ-threatening disease** - infection-related mortality is the dominant concern; add PCP prophylaxis

ABBREVIATIONS: SD-OCT = Spectral-Domain Optical Coherence Tomography; CKD = Chronic Kidney Disease; EULAR = European Alliance of Associations for Rheumatology; BP = Blood Pressure; MTX = Methotrexate; AZA = Azathioprine; MMF = Mycophenolate Mofetil; TPMT = Thiopurine Methyltransferase; eGFR = estimated Glomerular Filtration Rate; CBC = Complete Blood Count; KDIGO = Kidney Disease: Improving Global Outcomes; CYC = Cyclophosphamide; PCP (prophylaxis) = Pneumocystis jirovecii Pneumonia; HR = Hazard Ratio; CI = Confidence Interval; q4wk = every 4 weeks; BID = twice daily
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

CLINICAL PEARL — HYDROXYCHLOROQUINE IS A PRIMARY-CARE MEDICATION

Hydroxychloroquine is a primary-care medication. Initiating it and arranging baseline ophthalmology screening at the same visit is within PCP scope. It is associated with a **54% reduction in overall mortality (pooled HR 0.46; 95% CI 0.38–0.57)** and reduces flares and organ damage accrual.[5] Retinopathy risk is below **2% at 10 years** when dosed at or below 5 mg/kg/day.[33] Glucocorticoid minimization is the parallel priority: in older adults, steroid toxicity (which can result in osteoporosis, infection, diabetes, cataract etc) often causes more harm than the disease itself, and transition to steroid-sparing agents should not wait for subspecialty direction.

Non-Pharmacologic Care and Supportive Interventions

INTERVENTION	RATIONALE	PRIMARY CARE ACTION*
Sun protection[20]	**UV exposure triggers both cutaneous and systemic flares**	Counsel daily broad-spectrum SPF 50 or higher and UPF clothing; document as an SLE management behavior
Smoking cessation[30]	**Smoking** is associated with SLE incidence and reduces hydroxychloroquine efficacy	Offer cessation support at each visit
Vaccination[31]	**Infection is a leading cause of death in late-onset SLE**	Keep PCV20, influenza, recombinant zoster, and COVID-19 vaccines current; avoid live vaccines on immunosuppression
Bone health[22]	**Glucocorticoids** accelerate osteoporosis and fracture risk	**Calcium 1,000-1,200 mg/day + vitamin D 600-800 IU/day** with any anticipated chronic steroid course
Behavioral health[32]	**Depression drives non-adherence** and functional decline in older adults	Annual PHQ-9 with documented follow-up; offer telehealth behavioral health

ABBREVIATIONS: SLE = Systemic Lupus Erythematosus; UV = Ultraviolet; SPF = Sun Protection Factor; UPF = Ultraviolet Protection Factor; PHQ-9 = Patient Health Questionnaire-9
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Medication Safety and Key Interactions

INTERACTION/RISK	MECHANISM/CONSEQUENCE	RECOMMENDED ACTION*
Hydroxychloroquine retinopathy	Cumulative-dose retinal toxicity; risk **<2% at 10 years** but rises with CKD and tamoxifen co-use[33]	Dose at or below **5 mg/kg/day**; baseline SD-OCT + fundus autofluorescence; annual screening from initiation in high-risk patients
Azathioprine + allopurinol[34,35]	**Allopurinol blocks xanthine oxidase**, so 6-mercaptopurine accumulates to life-threatening myelosuppression - and gout is common in older SLE patients	**Avoid the combination**; prefer MMF or use febuxostat; if unavoidable, **cut AZA to ~25%** and monitor CBC weekly
Methotrexate + NSAIDs in CKD[36]	**NSAIDs reduce MTX renal clearance**, raising serum levels; CKD compounds the effect	**Avoid concurrent use when eGFR <60**; prefer acetaminophen; if an NSAID is needed, hold MTX and recheck CBC/creatinine
Glucocorticoid minimization[24]	**Chronic steroids** drive osteoporosis, hyperglycemia, infection, and cataracts in older adults	Target maintenance at or below **5 mg/day**; add a steroid-sparing agent rather than prolong steroids
Belimumab/anifrolumab[37]	**Added immunosuppression raises infection risk**; do not combine with rituximab/cyclophosphamide outside specialist direction	Confirm vaccinations are current; monitor for infection; coordinate biologic choice with rheumatology

ABBREVIATIONS: CKD = Chronic Kidney Disease; SD-OCT = Spectral-Domain Optical Coherence Tomography; MMF = Mycophenolate Mofetil; AZA = Azathioprine; CBC = Complete Blood Count; MTX = Methotrexate; NSAID = Nonsteroidal Anti-Inflammatory Drug; eGFR = estimated Glomerular Filtration Rate; SLE = Systemic Lupus Erythematosus
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

When to Refer

REFER TO	TRIGGER	TIMING
Rheumatology[38]	Any patient with **ANA at or above 1:80** and suggestive features; persistent activity despite HCQ + low-dose steroids	At suspicion - **do not wait** for the full serologic workup
Nephrology[38]	**UPCR >0.5 g/g**, active urine sediment, or rising creatinine	**Urgent** - for possible renal biopsy

REFER TO	TRIGGER	TIMING
Ophthalmology[38]	Hydroxychloroquine initiation; new visual symptoms on HCQ	Baseline at initiation; urgent if new symptoms
Cardiology[38]	QTc concern with HCQ + antiarrhythmics; suspected myocarditis or accelerated CAD	Routine for risk management; urgent for suspected myocarditis

ABBREVIATIONS: ANA = Antinuclear Antibody; HCQ = Hydroxychloroquine; UPCR = Urine Protein-to-Creatinine Ratio; QTc = Corrected QT interval; CAD = Coronary Artery Disease

Follow-Up Timing

CLINICAL STATE	FOLLOW-UP INTERVAL[9]	GERIATRIC NOTE
Stable/mild SLE	Every **3-6 months** with history, exam, CBC, creatinine, UA, anti-dsDNA, complement; keep health maintenance current	**Lower threshold** for subspecialty co-management than in younger patients
Moderately active disease	Every 1-3 months	**More frequent monitoring** across all categories in older adults
New medication started	Every **4-8 weeks** initially; CBC/LFTs q1-2 weeks at initiation	**Cytopenias** appear earlier at lower doses - monitor more closely
New severe manifestation	Every **2-4 weeks** or sooner, with specialist co-management	**Maintain a high index of suspicion for infection** masquerading as a flare

ABBREVIATIONS: SLE = Systemic Lupus Erythematosus; CBC = Complete Blood Count; UA = Urinalysis; anti-dsDNA = Anti-double-stranded DNA; LFT = Liver Function Test

Comorbidity Management — Primary Care Role

COMORBIDITY	TARGET	PRIMARY CARE ROLE[11]
Cardiovascular risk	Treat as **ASCVD risk-equivalent; BP <130/80 mmHg**	**Statin** in most older SLE patients regardless of calculated risk; intensify BP control - **17.7%** are untreated
Lupus nephritis/CKD	**UPCR <0.5 g/g**; stable eGFR	**Screen every 6 months**; ACE inhibitor/ARB for proteinuria; dose-adjust renally cleared drugs

COMORBIDITY	TARGET	PRIMARY CARE ROLE[11]
Infection risk	Vaccinations current; early evaluation of fever	**Distinguish flare from infection** before escalating immunosuppression
Bone health	Prevent glucocorticoid-induced fractures	DXA at baseline and every **1-2 years**; calcium + vitamin D; bisphosphonate per GIOP guidance

ABBREVIATIONS: ASCVD = Atherosclerotic Cardiovascular Disease; BP = Blood Pressure; CKD = Chronic Kidney Disease; UPCR = Urine Protein-to-Creatinine Ratio; eGFR = estimated Glomerular Filtration Rate; ACE = Angiotensin-Converting Enzyme; ARB = Angiotensin Receptor Blocker; DXA = Dual-energy X-ray Absorptiometry; GIOP = Glucocorticoid-Induced Osteoporosis; SLE = Systemic Lupus Erythematosus

Cost-Smart Options

MEDICATION CATEGORY	BRANDED AGENT*	COST-SMART OPTION*	NOTE
Antimalarial	Plaquenil(~**$150–$654/mo** retail)[39]	**Generic hydroxychloroquine**(~**$15–$20/mo**)[9]	Essential baseline therapy; low-cost generic; lowers flares and organ damage
Glucocorticoid	Medrol (~**$49/dose pack** retail);[40] Rayos (delayed-release, ~**~$2,706/mo** retail)[41]	Generic prednisone or methylprednisolone (~**$4–$10/mo**)[9]	Very low cost; use for acute flares and bridge only
Immunosuppressant	CellCept (~**$1,344/mo** retail)[42]	Generic mycophenolate mofetil (~**$22–$50/mo**)[9]	**~98%** savings with generic; first-line for lupus nephritis
Immunosuppressant	Imuran (~**$274–$328/mo** retail);[43] Trexall (~**$50–$100/mo**)[44]	Generic azathioprine (~**$12–$22/mo**); generic methotrexate (~**$10–$30/mo**)[9]	Both available as low-cost generics; standard steroid-sparing agents
Biologic	Benlysta SC (~**$7,173**/mo);[45] Rituxan off-label (~**$3,300**/mo drug cost per 6-mo cycle)[46]	GSK copay program: **$0/mo** for commercially insured (up to **$15,000/yr**); rituximab biosimilars (truxima, ruxience, riabni): ~**$2,780/mo** — **15–35% savings** vs. branded Rituxan[47]	Prior authorization required; patient assistance programs substantially reduce cost for eligible patients

ABBREVIATIONS:: SLE = Systemic Lupus Erythematosus; MMF = Mycophenolate Mofetil
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Patient Education and Adherence

Hydroxychloroquine adherence is the most clinically consequential patient behavior: it reduces flares, organ damage, and mortality. However, it requires specific instruction: take with food, expect annual retinal screening, and never stop without rheumatology direction, as abrupt discontinuation can trigger rebound flare. Older adults face compounding barriers such as polypharmacy, cognitive decline, and caregiver dependence, requiring adapted strategies like teach-back confirmation, large-print materials, and caregiver inclusion at all visits.

Two areas require explicit instruction at every encounter:

- **Flare recognition**: replace vague guidance with specific symptoms requiring a same-day call. For example, new leg or facial swelling, foamy or bloody urine, severe headache or confusion, pleuritic chest pain or dyspnea, new rash, or unexplained fever
- **Infection versus flare**: teach patients to report fever promptly and never self-adjust immunosuppressants, the treatment that controls a flare will worsen a concurrent infection. Daily sun protection addresses a modifiable flare trigger patients can act on independently and should be reinforced at every visit

DOCUMENTATION — PATIENT EDUCATION

Record patient-education topics in the encounter note - sun protection counseling, hydroxychloroquine adherence, flare-symptom teaching, and vaccination review. These are **billable SLE management behaviors** that demonstrate active management and support the specific **M32** code.

Quality Metrics Tie-In

MEASURE	TARGET/BASELINE	APPLICABILITY TO LUPUS
ACR RISE — Hydroxychloroquine Prescribing at Weight-Appropriate Dose[48]	**Denominator:** SLE patients with ≥2 encounters at RISE-participating practices during measurement year **Numerator:** HCQ prescribed at ≤5 mg/kg/day actual body weight **Exclusions**: hospice, death during measurement period, documented HCQ contraindication or intolerance, <2 SLE-related encounters; RISE baseline: 71.5% prescribed, only 62% at safe dose[13]	Document HCQ dose and actual body weight at every encounter; retinal monitoring referral required after **5 years of use** (sooner with renal impairment); dose adjustment required for CKD — failure to adjust increases retinal toxicity risk without improving disease control

MEASURE	TARGET/BASELINE	APPLICABILITY TO LUPUS
ACR RISE — Glucocorticoid Minimization[48]	**Denominator:** SLE patients currently prescribed glucocorticoids with ≥2 encounters during measurement year **Numerator:** Maintained at <7.5 mg/day prednisone equivalent for <90 days **Exclusions:** hospice, death during measurement period, <2 SLE-related encounters; RISE baseline: 18.5% on moderate-dose steroids ≥90 days[13]	Document steroid dose, duration, and taper plan at every visit; bridge to steroid-sparing agents (MMF, AZA, belimumab) early; document clinical rationale if continuation exceeds **90 days**; cumulative dose drives osteoporosis, cardiovascular, and infection risk
ACR RISE — Renal Monitoring[11,48]	**Denominator:** All SLE patients with ≥2 encounters during measurement year **Numerator:** UA + UPCR documented annually **Exclusions:** hospice, death during measurement period, pre-existing ESRD on dialysis, <2 SLE-related encounters; RISE baseline: only 39.5% adequately screened[13]	UA + UPCR with date documented at every encounter — not just when symptoms are present; lupus nephritis progresses silently; **UPCR >0.5 g/g triggers urgent nephrology referral**; inadequate renal screening is the most common quality gap in SLE primary care
HEDIS CBP: Controlling Blood Pressure (Star C14, MY2026)[49]	**Denominator:** MA enrollees 18–85 with hypertension diagnosis **Numerator:** BP <140/90 mm Hg documented **Exclusions:** hospice, death, palliative care, ESRD, pregnancy, I-SNP enrollment, frailty + advanced illness ≥66 years	SLE is an ASCVD risk-equivalent condition; SLE patients on glucocorticoids or with active nephritis carry compounded hypertension risk; nephritis-associated proteinuria warrants tighter BP target (<130/80); document BP at every SLE encounter to satisfy this measure

ABBREVIATIONS: ACR = American College of Rheumatology; ASCVD = atherosclerotic cardiovascular disease; AZA = azathioprine; BP = blood pressure; CBP = Controlling High Blood Pressure; CKD = chronic kidney disease; ESRD = end-stage renal disease; HCQ = hydroxychloroquine; HEDIS = Healthcare Effectiveness Data and Information Set; I-SNP = Institutional Special Needs Plan; MA = Medicare Advantage; MMF = mycophenolate mofetil; RISE = Rheumatology Informatics System for Effectiveness; SLE = systemic lupus erythematosus; UA = urinalysis; UPCR = urine protein-to-creatinine ratio

QUALITY OUTCOME

When **hydroxychloroquine** is prescribed at a **safe weight-based dose, glucocorticoids are minimized, and renal function is monitored every 6 months**, patients experience **less organ damage** and **fewer flares**. Hydroxychloroquine is associated with a **54% reduction in overall mortality (pooled HR 0.46; 95% CI 0.38–0.57)**, and these three clinical actions align with the **three ACR RISE quality measures** for SLE. No SLE-specific HEDIS or CMS Stars measures exist as of 2026; quality for this population is assessed through these ACR measures alongside cross-cutting measures for cardiovascular risk, bone health, and depression.

AAVBC PERSPECTIVE

*AAVBC encourages primary care providers to initiate and maintain **hydroxychloroquine therapy** for all patients with systemic lupus erythematosus unless a clear contraindication exists, without deferring this decision to rheumatology. Hydroxychloroquine is the foundation of SLE management, with evidence supporting reduced mortality, decreased organ damage, and lower flare frequency, and its initiation is within primary care scope. Weight-based dosing should not exceed **5 mg/kg/day or 400 mg/day**, and baseline funduscopic examination with OCT should be obtained at initiation, with annual monitoring from initiation in elderly patients, those with CKD, or concurrent tamoxifen use.*

*The parallel clinical goal is **steroid minimization**. Chronic glucocorticoid use should be tapered to the lowest effective dose, with a maintenance target of ≤5 mg/day prednisone, as treatment-related organ damage represents a leading source of morbidity in elderly SLE patients.*

*AAVBC also supports PCP ownership of the broader SLE comorbidity burden: cardiovascular risk management treating SLE as an ASCVD equivalent, renal screening with urinalysis and UPCR every 6 months, vaccination currency prior to and during immunosuppression, and annual depression screening. These actions are within primary care scope and should not be deferred pending rheumatology follow-up. **This helps ensure the right patients receive the right treatment and the right longitudinal monitoring at every stage of disease.***

5 CODING REMINDERS AND CASE EXAMPLES

Coding Specificity

SCENARIO	PREFERRED CODE	CODING SPECIFICITY GUIDANCE
Idiopathic SLE with documented organ involvement	**M32.11-M32.19 (specific organ)**	Select the organ-specific subcode - renal (M32.14), cardiac (M32.11/ M32.12), pulmonary (M32.13) - over M32.9; each maps to HCC 94; Pulmonary (M32.13) maps uniquely to HCC 280
Lupus nephritis with CKD	**M32.14 + N18.x**	Code both: **M32.14** documents HCC 94, and the concurrent CKD stage code (**N18.x**) documents its own separate, additive chronic kidney disease HCC

SCENARIO	PREFERRED CODE	CODING SPECIFICITY GUIDANCE
Drug-induced lupus, active	**M32.0**	**Maps to no HCC.** Document causative drug, temporal link, and resolution off the drug. Reclassify to idiopathic **M32.1x** if features persist
Cutaneous-only lupus	**L93.0/L93.1**	No SLE HCC. Do not use **M32** unless 2019 EULAR/ACR criteria are met
SLE without documented specifics	**M32.9** (last resort)	Use only when no organ involvement or drug etiology is documented. Thoroughly review the record first—national registry data shows that 60.5% of charts lack adequate renal screening or tracking documentation[13]

ABBREVIATIONS: SLE = Systemic Lupus Erythematosus; CKD = Chronic Kidney Disease; HCC = Hierarchical Condition Category; ICD-10-CM = International Classification of Diseases, 10th Revision, Clinical Modification; EULAR = European Alliance of Associations for Rheumatology; ACR = American College of Rheumatology

Annual Clinical Review and Confirmation

SLE is a chronic condition that must be **re-evaluated** and **re-documented** at least once **each calendar year** for risk-adjustment purposes. Carrying the diagnosis forward on a problem list without a supporting encounter note **does not** satisfy MEAT documentation; each year the record should show that SLE was monitored, evaluated, assessed, and treated. A problem-list entry alone **does not** meet this standard.

At the annual review, confirm whether the disease is **idiopathic** or **drug-induced**, because **this single determination decides whether the encounter maps to HCC 94** or to no HCC at all under **M32.0**. When a patient previously labeled drug-induced has persistent autoimmune features after the offending drug is withdrawn, **reclassify to idiopathic SLE** with updated documentation.

Confirm and code the organ systems involved using the specific **M32.1x** subcodes, and pair lupus nephritis **(M32.14)** with the appropriate CKD stage code so the additional CKD HCC is documented. Document the **hydroxychloroquine dose** relative to actual body weight, the most recent retinal-screening date,[17] the glucocorticoid taper status, and the every-6-month renal screening - the three **ACR RISE quality measures.**

Good Documentation — EHR Tips

EHR TIP	WHY IT HELPS	HOW TO IMPLEMENT
Problem-list specificity	**Prevents the default to M32.9**	**List the organ-specific code** (e.g., **M32.14** lupus nephritis) rather than generic SLE

EHR TIP	WHY IT HELPS	HOW TO IMPLEMENT
Etiology flag	**Avoids the M32.0 zero-HCC trap** and miscoding idiopathic SLE	Add a chart note or smartphrase confirming **idiopathic vs. drug-induced** status each year
HCQ dose + weight smartphrase	Satisfies the ACR HCQ quality measure and retinal-screening tracking	Build a template field for dose, actual body weight, and last SD-OCT date[17]
Renal-screening reminder	May lower **renal-screening gap**	Set a recurring 6-month UA + UPCR order reminder for every SLE patient
Disease-activity field	Demonstrates active management for MEAT	**Document a SLEDAI-2K score** or an activity statement at each visit

ABBREVIATIONS: EHR = Electronic Health Record; SLE = Systemic Lupus Erythematosus; HCQ = Hydroxychloroquine; SD-OCT = Spectral-Domain Optical Coherence Tomography; UA = Urinalysis; UPCR = Urine Protein-to-Creatinine Ratio; SLEDAI-2K = SLE Disease Activity Index 2000; ACR = American College of Rheumatology; HCC = Hierarchical Condition Category

Brief Case Examples

SUCCESS — Specific Organ Coding, Renal Escalation, Quality Measures Met

Patient: 68-year-old woman with SLE on hydroxychloroquine; annual review; arthralgia stable; routine labs show UPCR 0.6 g/g (previously 0.2 g/g); PMH hypertension, osteoporosis.

Documentation: 'SLE with glomerular involvement (lupus nephritis), **M32.14** - new proteinuria UPCR 0.6 g/g, active urine sediment; anti-dsDNA rising, C3 low. Hydroxychloroquine 5 mg/kg/day (actual body weight 68 kg); SD-OCT screening current. Urgent nephrology referral placed for possible renal biopsy. CKD stage 3 documented and coded **N18.30.**'

Outcome: M32.14 (HCC 94, CNA RAF 0.268) plus **N18.30 (CKD HCC)** both documented, accurately representing clinical complexity. Nephrology confirmed Class III lupus nephritis; mycophenolate started per KDIGO; renal monitoring scheduled every 1-3 months; quality measures for HCQ use and renal screening satisfied.

PITFALL — M32.0 Zero-HCC Trap and Vague Documentation

Documentation as written: 'Lupus, stable. On hydralazine for hypertension and plaquenil. Continue meds. **M32.0** (drug-induced lupus) added to problem list.'

Consequence: M32.0 maps to no HCC, so a fully managed patient receives zero risk-adjustment credit. The note does not establish drug etiology (no temporal relationship, no antihistone testing, no resolution off the drug) and the patient is actually on long-standing idiopathic SLE. No organ system, disease activity, or HCQ dose is documented.

RAF Impact: Idiopathic SLE with organ involvement (HCC 94, CNA RAF 0.268) is lost because **M32.0** carries no HCC. Any co-existing lupus nephritis with CKD would further under-document complexity if N18.x is also omitted.

Fix: Confirm etiology: if autoimmune features predate or persist independent of hydralazine, code idiopathic SLE with the specific organ subcode (e.g., **M32.14**) - HCC 94. Document HCQ dose with body

weight, disease activity, and every-6-month renal screening; reserve **M32.0** only for true drug-induced disease that resolves on withdrawal.

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