ICD-10 | Clinical Concepts for Orthopedics

ICD-10 Clinical Concepts Series

- Common Codes
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ICD-10 Compliance Date: **October 1, 2015**

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Common Codes

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Cervical Spine Disorders and Displacement (ICD-9-CM 722.0, 722.4, 722.71, 722.91, 723.4)

M50.00*	Cervical disc disorder with myelopathy, unspecified cervical region
M50.01	Cervical disc disorder with myelopathy, occipito-atlanto-axial region
M50.02	Cervical disc disorder with myelopathy, mid-cervical region
M50.03	Cervical disc disorder with myelopathy, cervicothoracic region
M50.10*	Cervical disc disorder with radiculopathy, unspecified cervical region
M50.11	Cervical disc disorder with radiculopathy, occipito-atlanto-axial region
M50.12	Cervical disc disorder with radiculopathy, mid-cervical region
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.20*	Other cervical disc displacement, unspecified cervical region
M50.21	Other cervical disc displacement, occipito-atlanto-axial region
M50.22	Other cervical disc displacement, mid-cervical region
M50.23	Other cervical disc displacement, cervicothoracic region
M50.30*	Other cervical disc degeneration, unspecified cervical region
M50.31	Other cervical disc degeneration, occipito-atlanto-axial region
M50.32	Other cervical disc degeneration, mid-cervical region
M50.33	Other cervical disc degeneration, cervicothoracic region
M50.80*	Other cervical disc disorders, unspecified cervical region
M50.81	Other cervical disc disorders, occipito-atlanto-axial region
M50.82	Other cervical disc disorders, mid-cervical region
M50.83	Other cervical disc disorders, cervicothoracic region
M50.90*	Cervical disc disorder, unspecified, unspecified cervical region
M50.91	Cervical disc disorder, unspecified, occipito-atlanto-axial region
M50.92	Cervical disc disorder, unspecified, mid-cervical region
M50.93	Cervical disc disorder, unspecified, cervicothoracic region

*Codes with a greater degree of specificity should be considered first.

Neck and Back Pain (ICD-9-CM 723.1, 724.1, 724.2, 724.3, 724.5)

M54.2	Cervicalgia
M54.30*	Sciatica, unspecified side
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.40*	Lumbago with sciatica, unspecified side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M54.5	Low back pain
M54.6	Pain in thoracic spine
M54.89	Other dorsalgia
M54.9*	Dorsalgia, unspecified

*Codes with a greater degree of specificity should be considered first.

Osteoarthritis of the Hip (ICD-9-CM 715.15, 715.25, 715.35, 715.95)

M16.0	Bilateral primary osteoarthritis of hip
M16.10*	Unilateral primary osteoarthritis, unspecified hip
M16.11	Unilateral primary osteoarthritis, right hip
M16.12	Unilateral primary osteoarthritis, left hip
M16.2	Bilateral osteoarthritis resulting from hip dysplasia
M16.30*	Unilateral osteoarthritis resulting from hip dysplasia, unspecified hip
M16.31	Unilateral osteoarthritis resulting from hip dysplasia, right hip
M16.32	Unilateral osteoarthritis resulting from hip dysplasia, left hip
M16.4	Bilateral post-traumatic osteoarthritis of hip
M16.50*	Unilateral post-traumatic osteoarthritis, unspecified hip
M16.51	Unilateral post-traumatic osteoarthritis, right hip
M16.52	Unilateral post-traumatic osteoarthritis, left hip
M16.6	Other bilateral secondary osteoarthritis of hip
M16.7	Other unilateral secondary osteoarthritis of hip
M16.9*	Osteoarthritis of hip, unspecified

*Codes with a greater degree of specificity should be considered first.

Osteoarthritis of the Knee (ICD-9-CM 715.16, 715.26, 715.36, 715.96)

M17.0	Bilateral primary osteoarthritis of knee
M17.10*	Unilateral primary osteoarthritis, unspecified knee
M17.11	Unilateral primary osteoarthritis, right knee
M17.12	Unilateral primary osteoarthritis, left knee
M17.2	Bilateral post-traumatic osteoarthritis of knee
M17.30*	Unilateral post-traumatic osteoarthritis, unspecified knee
M17.31	Unilateral post-traumatic osteoarthritis, right knee
M17.32	Unilateral post-traumatic osteoarthritis, left knee
M17.4	Other bilateral secondary osteoarthritis of knee
M17.5	Other unilateral secondary osteoarthritis of knee
M17.9*	Osteoarthritis of knee, unspecified

*Codes with a greater degree of specificity should be considered first.

Radiculopathy (Primary) (ICD-9-CM 723.4, 724.3, 724.4, 729.2)

M54.10*	Radiculopathy, site unspecified
M54.11	Radiculopathy, occipito-atlanto-axial region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.18	Radiculopathy, sacral and sacrococcygeal region
M54.30*	Sciatica, unspecified side
M54.31	Sciatica, right side
M54.32	Sciatica, left side

*Codes with a greater degree of specificity should be considered first.

Rheumatoid Arthritis (ICD-9-CM 714.0, 714.2) Excludes Combination Codes that Include Neuropathy, Bursitis and Nodule Codes, and the Codes that Indicate "Unspecified Site".

M05.611	Rheumatoid arthritis of right shoulder with involvement of other organs and systems
M05.612	Rheumatoid arthritis of left shoulder with involvement of other organs and systems
M05.619*	Rheumatoid arthritis of unspecified shoulder with involvement of other organs and systems
M05.621	Rheumatoid arthritis of right elbow with involvement of other organs and systems
M05.622	Rheumatoid arthritis of left elbow with involvement of other organs and systems
M05.629*	Rheumatoid arthritis of unspecified elbow with involvement of other organs and systems
M05.631	Rheumatoid arthritis of right wrist with involvement of other organs and systems
M05.632	Rheumatoid arthritis of left wrist with involvement of other organs and systems
M05.639*	Rheumatoid arthritis of unspecified wrist with involvement of other organs and systems
M05.641	Rheumatoid arthritis of right hand with involvement of other organs and systems
M05.642	Rheumatoid arthritis of left hand with involvement of other organs and systems
M05.649*	Rheumatoid arthritis of unspecified hand with involvement of other organs and systems
M05.651	Rheumatoid arthritis of right hip with involvement of other organs and systems
M05.652	Rheumatoid arthritis of left hip with involvement of other organs and systems
M05.659*	Rheumatoid arthritis of unspecified hip with involvement of other organs and systems
M05.661	Rheumatoid arthritis of right knee with involvement of other organs and systems

*Codes with a greater degree of specificity should be considered first.

Rheumatoid Arthritis (ICD-9-CM 714.0, 714.2) Excludes Combination Codes that Include Neuropathy, Bursitis and Nodule Codes, and the Codes that Indicate "Unspecified Site". (continued)

M05.662	Rheumatoid arthritis of left knee with involvement of other organs and systems
M05.669*	Rheumatoid arthritis of unspecified knee with involvement of other organs and systems
M05.671	Rheumatoid arthritis of right ankle and foot with involvement of other organs and systems
M05.672	Rheumatoid arthritis of left ankle and foot with involvement of other organs and systems
M05.679*	Rheumatoid arthritis of unspecified ankle and foot with involvement of other organs and systems
M05.69	Rheumatoid arthritis of multiple sites with involvement of other organs and systems
M05.711	Rheumatoid arthritis with rheumatoid factor of right shoulder without organ or systems involvement
M05.712	Rheumatoid arthritis with rheumatoid factor of left shoulder without organ or systems involvement
M05.719*	Rheumatoid arthritis with rheumatoid factor of unspecified shoulder without organ or systems involvement
M05.721	Rheumatoid arthritis with rheumatoid factor of right elbow without organ or systems involvement
M05.722	Rheumatoid arthritis with rheumatoid factor of left elbow without organ or systems involvement
M05.729*	Rheumatoid arthritis with rheumatoid factor of unspecified elbow without organ or systems involvement
M05.731	Rheumatoid arthritis with rheumatoid factor of right wrist without organ or systems involvement
M05.732	Rheumatoid arthritis with rheumatoid factor of left wrist without organ or systems involvement
M05.739*	Rheumatoid arthritis with rheumatoid factor of unspecified wrist without organ or systems involvement
M05.741	Rheumatoid arthritis with rheumatoid factor of right hand without organ or systems involvement

*Codes with a greater degree of specificity should be considered first.

Rheumatoid Arthritis (ICD-9-CM 714.0, 714.2) Excludes Combination Codes that Include Neuropathy, Bursitis and Nodule Codes, and the Codes that Indicate "Unspecified Site". (continued)

M05.742	Rheumatoid arthritis with rheumatoid factor of left hand without organ or systems involvement
M05.749*	Rheumatoid arthritis with rheumatoid factor of unspecified hand without organ or systems involvement
M05.751	Rheumatoid arthritis with rheumatoid factor of right hip without organ or systems involvement
M05.752	Rheumatoid arthritis with rheumatoid factor of left hip without organ or systems involvement
M05.759*	Rheumatoid arthritis with rheumatoid factor of unspecified hip without organ or systems involvement
M05.761	Rheumatoid arthritis with rheumatoid factor of right knee without organ or systems involvement
M05.762	Rheumatoid arthritis with rheumatoid factor of left knee without organ or systems involvement
M05.769*	Rheumatoid arthritis with rheumatoid factor of unspecified knee without organ or systems involvement
M05.771	Rheumatoid arthritis with rheumatoid factor of right ankle and foot without organ or systems involvement
M05.772	Rheumatoid arthritis with rheumatoid factor of left ankle and foot without organ or systems involvement
M05.779*	Rheumatoid arthritis with rheumatoid factor of unspecified ankle and foot without organ or systems involvement
M05.79	Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement
M05.811	Other rheumatoid arthritis with rheumatoid factor of right shoulder
M05.812	Other rheumatoid arthritis with rheumatoid factor of left shoulder
M05.819*	Other rheumatoid arthritis with rheumatoid factor of unspecified shoulder
M05.821	Other rheumatoid arthritis with rheumatoid factor of right elbow
M05.822	Other rheumatoid arthritis with rheumatoid factor of left elbow
M05.829*	Other rheumatoid arthritis with rheumatoid factor of unspecified elbow
M05.831	Other rheumatoid arthritis with rheumatoid factor of right wrist
M05.832	Other rheumatoid arthritis with rheumatoid factor of left wrist

*Codes with a greater degree of specificity should be considered first.

Rheumatoid Arthritis (ICD-9-CM 714.0, 714.2) Excludes Combination Codes that Include Neuropathy, Bursitis and Nodule Codes, and the Codes that Indicate "Unspecified Site". (continued)

M05.839*	Other rheumatoid arthritis with rheumatoid factor of unspecified wrist
M05.841	Other rheumatoid arthritis with rheumatoid factor of right hand
M05.842	Other rheumatoid arthritis with rheumatoid factor of left hand
M05.849*	Other rheumatoid arthritis with rheumatoid factor of unspecified hand
M05.851	Other rheumatoid arthritis with rheumatoid factor of right hip
M05.852	Other rheumatoid arthritis with rheumatoid factor of left hip
M05.859*	Other rheumatoid arthritis with rheumatoid factor of unspecified hip
M05.861	Other rheumatoid arthritis with rheumatoid factor of right knee
M05.862	Other rheumatoid arthritis with rheumatoid factor of left knee
M05.869*	Other rheumatoid arthritis with rheumatoid factor of unspecified knee
M05.871	Other rheumatoid arthritis with rheumatoid factor of right ankle and foot
M05.872	Other rheumatoid arthritis with rheumatoid factor of left ankle and foot
M05.879*	Other rheumatoid arthritis with rheumatoid factor of unspecified ankle and foot
M05.89	Other rheumatoid arthritis with rheumatoid factor of multiple sites
M05.9*	Rheumatoid arthritis with rheumatoid factor, unspecified
M06.00*	Rheumatoid arthritis without rheumatoid factor, unspecified site
M06.011	Rheumatoid arthritis without rheumatoid factor, right shoulder
M06.012	Rheumatoid arthritis without rheumatoid factor, left shoulder
M06.019*	Rheumatoid arthritis without rheumatoid factor, unspecified shoulder
M06.021	Rheumatoid arthritis without rheumatoid factor, right elbow
M06.022	Rheumatoid arthritis without rheumatoid factor, left elbow
M06.029*	Rheumatoid arthritis without rheumatoid factor, unspecified elbow
M06.031	Rheumatoid arthritis without rheumatoid factor, right wrist
M06.032	Rheumatoid arthritis without rheumatoid factor, left wrist
M06.039*	Rheumatoid arthritis without rheumatoid factor, unspecified wrist
M06.041	Rheumatoid arthritis without rheumatoid factor, right hand
M06.042	Rheumatoid arthritis without rheumatoid factor, left hand
M06.049*	Rheumatoid arthritis without rheumatoid factor, unspecified hand
M06.051	Rheumatoid arthritis without rheumatoid factor, right hip
M06.052	Rheumatoid arthritis without rheumatoid factor, left hip
M06.059*	Rheumatoid arthritis without rheumatoid factor, unspecified hip
M06.061	Rheumatoid arthritis without rheumatoid factor, right knee

*Codes with a greater degree of specificity should be considered first.

Rheumatoid Arthritis (ICD-9-CM 714.0, 714.2) Excludes Combination Codes that Include Neuropathy, Bursitis and Nodule Codes, and the Codes that Indicate "Unspecified Site". (continued)

M06.062	Rheumatoid arthritis without rheumatoid factor, left knee
M06.069*	Rheumatoid arthritis without rheumatoid factor, unspecified knee
M06.071	Rheumatoid arthritis without rheumatoid factor, right ankle and foot
M06.072	Rheumatoid arthritis without rheumatoid factor, left ankle and foot
M06.079*	Rheumatoid arthritis without rheumatoid factor, unspecified ankle and foot
M06.08	Rheumatoid arthritis without rheumatoid factor, vertebrae
M06.09	Rheumatoid arthritis without rheumatoid factor, multiple sites
M06.80*	Other specified rheumatoid arthritis, unspecified site
M06.811	Other specified rheumatoid arthritis, right shoulder
M06.812	Other specified rheumatoid arthritis, left shoulder
M06.819*	Other specified rheumatoid arthritis, unspecified shoulder
M06.821	Other specified rheumatoid arthritis, right elbow
M06.822	Other specified rheumatoid arthritis, left elbow
M06.829*	Other specified rheumatoid arthritis, unspecified elbow
M06.831	Other specified rheumatoid arthritis, right wrist
M06.832	Other specified rheumatoid arthritis, left wrist
M06.839*	Other specified rheumatoid arthritis, unspecified wrist
M06.841	Other specified rheumatoid arthritis, right hand
M06.842	Other specified rheumatoid arthritis, left hand
M06.849*	Other specified rheumatoid arthritis, unspecified hand
M06.851	Other specified rheumatoid arthritis, right hip
M06.852	Other specified rheumatoid arthritis, left hip
M06.859*	Other specified rheumatoid arthritis, unspecified hip
M06.861	Other specified rheumatoid arthritis, right knee
M06.862	Other specified rheumatoid arthritis, left knee
M06.869*	Other specified rheumatoid arthritis, unspecified knee
M06.871	Other specified rheumatoid arthritis, right ankle and foot
M06.872	Other specified rheumatoid arthritis, left ankle and foot
M06.879*	Other specified rheumatoid arthritis, unspecified ankle and foot
M06.88	Other specified rheumatoid arthritis, vertebrae
M06.89	Other specified rheumatoid arthritis, multiple sites
M06.9*	Rheumatoid arthritis, unspecified

*Codes with a greater degree of specificity should be considered first.

Selected Shoulder Conditions (ICD-9-CM 726.0, 726.10 to 726.19 range, 726.2, 727.61)

M66.211	Spontaneous rupture of extensor tendons, right shoulder
M66.212	Spontaneous rupture of extensor tendons, left shoulder
M66.219*	Spontaneous rupture of extensor tendons, unspecified shoulder
M66.811	Spontaneous rupture of other tendons, right shoulder
M66.812	Spontaneous rupture of other tendons, left shoulder
M66.819*	Spontaneous rupture of other tendons, unspecified shoulder
M75.00*	Adhesive capsulitis of unspecified shoulder
M75.01	Adhesive capsulitis of right shoulder
M75.02	Adhesive capsulitis of left shoulder
M75.100*	Unspecified rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic
M75.101*	Unspecified rotator cuff tear or rupture of right shoulder, not specified as traumatic
M75.102*	Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic
M75.110*	Incomplete rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic
M75.111	Incomplete rotator cuff tear or rupture of right shoulder, not specified as traumatic
M75.112	Incomplete rotator cuff tear or rupture of left shoulder, not specified as traumatic
M75.120*	Complete rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic
M75.121	Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic
M75.122	Complete rotator cuff tear or rupture of left shoulder, not specified as traumatic
M75.20*	Bicipital tendinitis, unspecified shoulder
M75.21	Bicipital tendinitis, right shoulder
M75.22	Bicipital tendinitis, left shoulder
M75.30*	Calcific tendinitis of unspecified shoulder
M75.31	Calcific tendinitis of right shoulder
M75.32	Calcific tendinitis of left shoulder
M75.40*	Impingement syndrome of unspecified shoulder
M75.41	Impingement syndrome of right shoulder

*Codes with a greater degree of specificity should be considered first.

Selected Shoulder Conditions (ICD-9-CM 726.0, 726.10 to 726.19 range, 726.2, 727.61) (continued)

M75.42	Impingement syndrome of left shoulder
M75.50*	Bursitis of unspecified shoulder
M75.51	Bursitis of right shoulder
M75.52	Bursitis of left shoulder
M75.80*	Other shoulder lesions, unspecified shoulder
M75.81	Other shoulder lesions, right shoulder
M75.82	Other shoulder lesions, left shoulder
M75.90*	Shoulder lesion, unspecified, unspecified shoulder
M75.91*	Shoulder lesion, unspecified, right shoulder
M75.92*	Shoulder lesion, unspecified, left shoulder

*Codes with a greater degree of specificity should be considered first.

Spinal Stenosis of the Lumbar Region (ICD-9-CM 724.02)

M48.06	Spinal stenosis, lumbar region
M48.07	Spinal stenosis, lumbosacral region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region

*Codes with a greater degree of specificity should be considered first.

Selected Sprains – Rotator Cuff, Cruciate Ligament, and Ankle (ICD-9-CM 840.4, 844.0, 844.1, 844.2, 844.8, 845.01, 845.00 to 845.09 range, 905.7, V58.89)

S43.421A	Sprain of right rotator cuff capsule, initial encounter
S43.421D	Sprain of right rotator cuff capsule, subsequent encounter
S43.421S	Sprain of right rotator cuff capsule, sequela
S43.422A	Sprain of left rotator cuff capsule, initial encounter
S43.422D	Sprain of left rotator cuff capsule, subsequent encounter
S43.422S	Sprain of left rotator cuff capsule, sequela
S43.429A*	Sprain of unspecified rotator cuff capsule, initial encounter
S43.429D*	Sprain of unspecified rotator cuff capsule, subsequent encounter
S43.429S*	Sprain of unspecified rotator cuff capsule, sequela
S83.501A*	Sprain of unspecified cruciate ligament of right knee, initial encounter
S83.501D*	Sprain of unspecified cruciate ligament of right knee, subsequent encounter
S83.501S*	Sprain of unspecified cruciate ligament of right knee, sequela
S83.502A*	Sprain of unspecified cruciate ligament of left knee, initial encounter
S83.502D*	Sprain of unspecified cruciate ligament of left knee, subsequent encounter
S83.502S*	Sprain of unspecified cruciate ligament of left knee, sequela
S83.509A*	Sprain of unspecified cruciate ligament of unspecified knee, initial encounter
S83.509D*	Sprain of unspecified cruciate ligament of unspecified knee, subsequent encounter
S83.509S*	Sprain of unspecified cruciate ligament of unspecified knee, sequela
S83.511A	Sprain of anterior cruciate ligament of right knee, initial encounter
S83.511D	Sprain of anterior cruciate ligament of right knee, subsequent encounter
S83.511S	Sprain of anterior cruciate ligament of right knee, sequela
S83.512A	Sprain of anterior cruciate ligament of left knee, initial encounter
S83.512D	Sprain of anterior cruciate ligament of left knee, subsequent encounter
S83.512S	Sprain of anterior cruciate ligament of left knee, sequela
S83.519A*	Sprain of anterior cruciate ligament of unspecified knee, initial encounter
S83.519D*	Sprain of anterior cruciate ligament of unspecified knee, subsequent encounter
S83.519S*	Sprain of anterior cruciate ligament of unspecified knee, sequela
S83.521A	Sprain of posterior cruciate ligament of right knee, initial encounter
S83.521D	Sprain of posterior cruciate ligament of right knee, subsequent encounter

*Codes with a greater degree of specificity should be considered first.

Selected Sprains – Rotator Cuff, Cruciate Ligament, and Ankle (ICD-9-CM 840.4, 844.0, 844.1, 844.2, 844.8, 845.01, 845.00 to 845.09 range, 905.7, V58.89) (continued)

S83.521S	Sprain of posterior cruciate ligament of right knee, sequela
S83.522A	Sprain of posterior cruciate ligament of left knee, initial encounter
S83.522D	Sprain of posterior cruciate ligament of left knee, subsequent encounter
S83.522S	Sprain of posterior cruciate ligament of left knee, sequela
S83.529A*	Sprain of posterior cruciate ligament of unspecified knee, initial encounter
S83.529D*	Sprain of posterior cruciate ligament of unspecified knee, subsequent encounter
S83.529S*	Sprain of posterior cruciate ligament of unspecified knee, sequela
S93.401A*	Sprain of unspecified ligament of right ankle, initial encounter
S93.401D*	Sprain of unspecified ligament of right ankle, subsequent encounter
S93.401S*	Sprain of unspecified ligament of right ankle, sequela
S93.402A*	Sprain of unspecified ligament of left ankle, initial encounter
S93.402D*	Sprain of unspecified ligament of left ankle, subsequent encounter
S93.402S*	Sprain of unspecified ligament of left ankle, sequela
S93.409A*	Sprain of unspecified ligament of unspecified ankle, initial encounter
S93.409D*	Sprain of unspecified ligament of unspecified ankle, subsequent encounter
S93.409S*	Sprain of unspecified ligament of unspecified ankle, sequela
S93.411A	Sprain of calcaneofibular ligament of right ankle, initial encounter
S93.411D	Sprain of calcaneofibular ligament of right ankle, subsequent encounter
S93.411S	Sprain of calcaneofibular ligament of right ankle, sequela
S93.412A	Sprain of calcaneofibular ligament of left ankle, initial encounter
S93.412D	Sprain of calcaneofibular ligament of left ankle, subsequent encounter
S93.412S	Sprain of calcaneofibular ligament of left ankle, sequela
S93.419A*	Sprain of calcaneofibular ligament of unspecified ankle, initial encounter
S93.419D*	Sprain of calcaneofibular ligament of unspecified ankle, subsequent encounter
S93.419S*	Sprain of calcaneofibular ligament of unspecified ankle, sequela
S93.421A	Sprain of deltoid ligament of right ankle, initial encounter
S93.421D	Sprain of deltoid ligament of right ankle, subsequent encounter
S93.421S	Sprain of deltoid ligament of right ankle, sequela
S93.422A	Sprain of deltoid ligament of left ankle, initial encounter
S93.422D	Sprain of deltoid ligament of left ankle, subsequent encounter

*Codes with a greater degree of specificity should be considered first.

Selected Sprains – Rotator Cuff, Cruciate Ligament, and Ankle (ICD-9-CM 840.4, 844.0, 844.1, 844.2, 844.8, 845.01, 845.00 to 845.09 range, 905.7, V58.89)(continued)

S93.422S	Sprain of deltoid ligament of left ankle, sequela
S93.429A*	Sprain of deltoid ligament of unspecified ankle, initial encounter
S93.429D*	Sprain of deltoid ligament of unspecified ankle, subsequent encounter
S93.429S*	Sprain of deltoid ligament of unspecified ankle, sequela
S93.431A	Sprain of tibiofibular ligament of right ankle, initial encounter
S93.431D	Sprain of tibiofibular ligament of right ankle, subsequent encounter
S93.431S	Sprain of tibiofibular ligament of right ankle, sequela
S93.432A	Sprain of tibiofibular ligament of left ankle, initial encounter
S93.432D	Sprain of tibiofibular ligament of left ankle, subsequent encounter
S93.432S	Sprain of tibiofibular ligament of left ankle, sequela
S93.439A*	Sprain of tibiofibular ligament of unspecified ankle, initial encounter
S93.439D*	Sprain of tibiofibular ligament of unspecified ankle, subsequent encounter
S93.439S*	Sprain of tibiofibular ligament of unspecified ankle, sequela
S93.491A	Sprain of other ligament of right ankle, initial encounter
S93.491D	Sprain of other ligament of right ankle, subsequent encounter
S93.491S	Sprain of other ligament of right ankle, sequela
S93.492A	Sprain of other ligament of left ankle, initial encounter
S93.492D	Sprain of other ligament of left ankle, subsequent encounter
S93.492S	Sprain of other ligament of left ankle, sequela
S93.499A*	Sprain of other ligament of unspecified ankle, initial encounter
S93.499D*	Sprain of other ligament of unspecified ankle, subsequent encounter
S93.499S*	Sprain of other ligament of unspecified ankle, sequela

*Codes with a greater degree of specificity should be considered first.

Thoracic, Thoracolumbar, and Lumbosacral Intervertebral Disc Disorders (ICD-9-CM 722.10, 722.11, 722.31, 722.32, 722.51, 722.52, 722.72, 722.73, 722.90, 722.92, 722.93, 724.4)

M51.04	Intervertebral disc disorders with myelopathy, thoracic region
M51.05	Intervertebral disc disorders with myelopathy, thoracolumbar region
M51.06	Intervertebral disc disorders with myelopathy, lumbar region
M51.07	Intervertebral disc disorders with myelopathy, lumbosacral region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.34	Other intervertebral disc degeneration, thoracic region
M51.35	Other intervertebral disc degeneration, thoracolumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M51.44	Schmorl's nodes, thoracic region
M51.45	Schmorl's nodes, thoracolumbar region
M51.46	Schmorl's nodes, lumbar region
M51.47	Schmorl's nodes, lumbosacral region
M51.84	Other intervertebral disc disorders, thoracic region
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M51.9*	Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder

*Codes with a greater degree of specificity should be considered first.

Clinical Documentation Tips

ICD-10 Compliance Date: **October 1, 2015**

Specifying anatomical location and laterality required by ICD-10 is easier than you think. This detail reflects how physicians and clinicians communicate and to what they pay attention - it is a matter of ensuring the information is captured in your documentation.

In ICD-10-CM, there are three main categories of changes:

- **Definition Changes**
- **Terminology Differences**
- **Increased Specificity**

For orthopedics the focus is on increased specificity. Over 1/3 of the expansion of ICD-10 codes is due to the addition of laterality (left, right, or bilateral). Physicians and other clinicians likely already note laterality when evaluating the clinically pertinent anatomical site(s).

ICD-10 Code Examples

M21.722	Unequal limb length (acquired), left humerus
M25.561	Pain in right knee
M25.562	Pain in left knee
S72.344A	Nondisplaced spiral fracture of shaft of right femur, initial encounter for closed fracture

FRACTURES

Increased Specificity

When documenting fractures, include the following parameters:

1.	Type	e.g. Open, closed, pathological, neoplastic disease, stress
2.	Pattern	e.g. Comminuted, oblique, segmental, spiral, transverse
3.	Etiology to document in the external cause codes	
4.	Encounter of care	e.g. Initial, subsequent, sequelae
5.	Healing status, if subsequent encounter	e.g. Normal healing, delayed healing, nonunion, malunion
6.	Localization	e.g. Shaft, head, neck, distal, proximal, styloid
7.	Displacement	e.g. Displaced, non displaced
8.	Classification	e.g. Gustilo-Anderson, Salter-Harris
9.	Any complications, whether acute or delayed	e.g. Direct result of trauma sustained

In addition, depending on the circumstances, it may be necessary to document intra-articular or extra-articular involvement. For certain conditions, the bone may be affected at the proximal or distal end. Though the portion of the bone affected may be at the joint at either end, the site designation will be the bone, not the joint.

ICD-10 Code Examples

S52.521A	Torus fracture of lower end of right radius, initial encounter for closed fracture
S52.521D	Torus fracture of lower end of right radius, subsequent encounter for fracture with routine healing
S42.021K	Displaced fracture of the shaft of right clavicle, subsequent for fracture with nonunion

ARTHRITIS

Increased Specificity

In ICD-10-CM, there are specific codes for primary and secondary arthritis. Within the secondary arthritis codes there are specific codes for post-traumatic osteoarthritis and other secondary osteoarthritis. For secondary osteoarthritis of the hip there is also a code for dysplastic osteoarthritis.

Arthritis codes in ICD-10-CM is both similar and different than ICD-9-CM. For example, currently, in ICD-9, osteoarthritis can be described as degenerative, hypertrophic, or secondary to other factors, and the type as generalized or localized. ICD-10 provides more options for the coding osteoarthritis related encounters, including:

- Generalized forms of osteoarthritis or arthritis where multiple joints are involved.
- Localized forms of osteoarthritis with more specificity that includes primary versus secondary types, subtypes, laterality, and joint involvement.

Indicate the type, location, and specific bones and joints (multiple sites if applicable) involved in the disease. In addition, describe any related underlying diseases or conditions.

ICD-10 Code Examples

M19.041	Primary osteoarthritis right hand
M19.241	Secondary osteoarthritis, right hand
M05.432	Rheumatoid myopathy with rheumatoid arthritis of left wrist

INJURIES

Increased Specificity

ICD-9 used separate "E codes" to record external causes of injury. ICD-10 better incorporates these codes and expands sections on poisonings and toxins.

When documenting injuries, include the following:

1. Episode of Care — e.g. Initial, subsequent, sequelae
2. Injury site — Be as specific as possible
3. Etiology — How was the injury sustained (e.g. sports, motor vehicle crash, pedestrian, slip and fall, environmental exposure, etc.)?
4. Place of Occurrence — e.g. School, work, etc.

Initial encounters may also require, where appropriate:

1. Intent — e.g. Unintentional or accidental, self-harm, etc.
2. Status — e.g. Civilian, military, etc.

ICD-10 Code Examples

Example 1: A left knee strain injury that occurred on a private recreational playground when a child landed incorrectly from a trampoline:

- Injury: S86.812A, Strain of other muscle(s) and tendon(s) at lower leg level, left leg, initial encounter
- External cause: W09.8xxA, Fall on or from other playground equipment, initial encounter
- Place of occurrence: Y92.838, Other recreation area as the place of occurrence of the external cause
- Activity: Y93.44, Activities involving rhythmic movement, trampoline jumping

Example 2: On October 31st, Kelly was seen in the ER for shoulder pain and X-rays indicated there was a fracture of the right clavicle, shaft. She returned three months later with complaints of continuing pain. X-rays indicated a nonunion. The second encounter for the right clavicle fracture is coded as ***S42.021K, Displaced fracture of the shaft of right clavicle, subsequent for fracture with nonunion.***

Clinical Scenarios

ICD-10 Compliance Date: **October 1, 2015**

Quality clinical documentation is essential for communicating the intent of an encounter, confirming medical necessity, and providing detail to support ICD-10 code selection. In support of this objective, we have provided outpatient focused scenarios to illustrate specific ICD-10 documentation and coding nuances related to your specialty.

The following scenarios were natively coded in ICD-10-CM and ICD-9-CM. As patient history and circumstances will vary, these brief scenarios are illustrative in nature and should not be strictly interpreted or used as documentation and coding guidelines. Each scenario is selectively coded to highlight specific topics; therefore, only a subset of the relevant codes are presented.

Scenario 1: Fracture Follow-Up Visit

Scenario Details

Chief Complaint

- First follow-up visit post fracture to left femur.

History

- 85 year old retired male sustained a crush **injury to his left femur from a forklift accident while he was a consumer in a building store**[1]. The forklift hit his left leg and crushed it.
- Patient **sustained an open, displaced, transverse fracture of his left middle femur shaft. There was a 2-3 cm skin avulsion and moderate surrounding tissue damage to his left lateral thigh approximately five inches above the knee. Gustilo Class II fracture**[2].
- S/P ORIF of left femur two weeks prior to today's visit. Received tetanus vaccine while in hospital.
- Patient has been receiving daily PT at home since he left the hospital one week ago. Patient is non-weight bearing on the LLE.

Exam

- X-ray today of left femur compared to surgical films show good healing. All surgical plates and screws intact. **No signs of infection at the surgical site**[3].
- Patient reports that pain is decreasing daily. Able to bend left knee 45º, with full ROM to left ankle and toes. Mild pedal edema noted. Circulation to left foot is excellent with palpable pedal pulses and brisk capillary refill <2 sec.
- Physical therapy reports patient is progressing well and is compliant with ROM instructions. Gait steady with LLE in hinged knee brace and crutches.

Assessment and Plan

- Left femur fracture is healing appropriately.
- Discontinue home PT. Patient to begin daily rehab at PT Center tomorrow. Continue to increase PT exercises. Updated orders sent to PT office and discussed with patient.
- See patient in office in 4 weeks for repeat films, evaluation of surgical site and PT progression.

Summary of ICD-10-CM Impacts

Clinical Documentation

1. Describes circumstances of injury. With ICD-10-CM, you must re-document or reference extensive details surrounding the circumstances of injury to ensure correct coding and proper claims processing. This includes timeframe, etiology, episode of care, injury site, cause, and place of occurrence. According to the ICD-10-CM guidelines, place of occurrence, activity and work status codes are only coded on the first visit. Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequelae) for each encounter for which the injury or condition is being treated. As this is a subsequent encounter, this information is reflected in the 7th character of the ICD-10-CM code (e.g., V83.7xxD for V83.7xxD, Person on outside of special industrial vehicle injured in nontraffic accident).

   Note that per the guidelines there is no national requirement for mandatory ICD-10-CM external cause code reporting. You may be required to report them based on a state based external cause code mandate (for example, for a trauma registry) or as required by a particular payor. Providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and may assist in claims processing/insurance coordination of benefits.

2. Describes the fracture/injury – With ICD-10-CM, you need to document specifics about the type of fracture injury to ensure correct coding. Include information on the side, location (make reference to the appropriate anatomical landmarks) and classification. The fracture description above is well defined and includes description that supports the necessary items such as traumatic, open, displaced, middle of femur shaft, subsequent encounter, routine healing, and fracture classification Gustilo class II. This information is reflected in the 7th character of the ICD-10-CM code (e.g., S72.322E)
3. Note the presence of infection (if any). Documenting whether there are signs of infection will support if additional surgical intervention is necessary and if additional adverse sequelae develop.

Scenario 1: Fracture Follow-Up Visit (continued)

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
821.11	Open fracture of shaft of femur	S72.322E	Displaced transverse fracture of shaft of left femur, subsequent encounter for open fracture type I or II with routine healing
E919.2	Accidents caused by lifting machines and appliances	W23.0xxD	Caught, crushed, jammed, or pinched between moving objects subsequent encounter
N/A		V83.7xxD	Person on outside of special industrial vehicle injured in nontraffic accident

Other Impacts

- Correctly coding the fracture ensures the provider will be reimbursed for appropriate follow-up visits and that the patient can receive appropriate outpatient (i.e. PT, imaging, etc.) services. Uncomplicated follow-up visits may be bundled by a payor.
- The circumstances of injury such as where and how it occurred are important for claims processing and coordination of benefits.

Scenario 2: Shoulder ROM Office Visit

Scenario Details

Chief Complaint

- "Frozen" right shoulder[1]

History

- 52 year old female with right shoulder pain; "6" on 1-10 scale. Seen in my office two weeks ago for same c/o; prolonged symptoms after oral non-steroidal challenge. **Decreased ROM noted. Difficulty with daily activities including carrying briefcase, driving, dressing and cooking noted. Patient states sleep is also being affected**[2].
- Takes NSAID twice daily for pain. Patient reports the medication "helps some."

Exam

- Right shoulder film negative. Tenderness noted.
- Active and passive range of motion remain to right shoulder is significantly decreased.
- Neurological exam normal.

Assessment and Plan

- Adhesive capsulitis of right shoulder.
- Administered subacromial corticosteroid injection, right shoulder.
- Pain control discussed. Patient declines Rx oral corticosteroid medications. Recommended to continue with NSAID, discussed side effects.
- PT therapy for ROM of shoulder
- Scheduled a follow-up visit in 2 weeks.

Summary of ICD-10-CM Impacts

Clinical Documentation

1. ICD-10-CM can now capture the side and specific bone or joint. Including the specific information ensures the correct "side" code is assigned.
2. Be as specific as possible when describing the effects of the condition.

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
726.0	Adhesive capsulitis of shoulder	M75.01	Adhesive capsulitis of right shoulder

Other Impacts

Identifying the affected side is important, as some payers will not reimburse claims with "unspecified" codes.

Scenario 3: Tear of Medial Meniscus With Anterior Cruciate Ligament Injury

Scenario Details

Chief Complaint

- Instability of right knee.

History

- This 29 year old single male, new patient, presents today for evaluation of an injury to his right knee. Patient states he initially injured his right knee one year ago playing hockey and then reinjured the same knee three weeks ago playing softball.
- He describes the pain as 6/10, with throbbing intermittently; pain does not interfere with sleep. He states the symptoms are made worse with exercise, squatting, kneeling, and certain twisting motions. Locking and clicking present. Symptoms seem to improve with rest and no physical activity.
- MRI from one year ago shows partial right anterior cruciate ligament tear.
- MRI films following an ER visit three weeks ago show a tear of the right medial meniscus.
- Treatment has consisted of bracing and exercise. He has had no physical therapy, no injections, and has never used a cane or a crutch.
- He complains of instability of his right knee, especially with directional change and specifically with pivoting.
- No history of rheumatoid arthritis or osteoarthritis.
- 13 point review of systems negative; past medical history noncontributory.

Exam

- Vital signs: BP: 110/65 HR: 61 R: 20 T: 98.6 Ht: 6.0 Wt: 201 lbs.
- Slight antalgic gait observed.
- No gross deformities of the lower extremities, range of motion of the both knees is within normal limits. Palpable patellofemoral crepitation with moderate positive patellar squeeze test.
- Obvious grade 2 to 3+ Lachman exam with poor endpoint and grossly positive shift.
- Pain present with palpation to the mid portion of the medial joint line; aggravated by Apley compression test and McMurray maneuver.
- **Effusion palpable.**
- Posterior cruciate ligament and collateral ligaments appear intact.
- Neurovascular exam intact bilaterally.
- Remainder of physical examination within normal limits.

Assessment and Plan

- Medial meniscus tear of right knee; symptomatic with pain and instability.
- Functional instability due to anterior cruciate ligament insufficiency.
- Will treat conservatively for now.

Scenario 3: Tear of Medial Meniscus With Anterior Cruciate Ligament Injury (continued)

Summary of ICD-10-CM Impacts

Clinical Documentation

1. In ICD-10-CM, old disruptions of any of the four knee ligaments map to chronic instability of the knee. Following coding guidelines in both ICD-9 and ICD-10, the old disruption and chronic instability are not reported in addition to the current injury.
2. Pain may be considered integral to the underlying medical condition of the medial meniscus tear, and thus is not coded separately as a symptom.
3. In this example, the medial meniscus tear is coded with unspecified as the information in the medical record is insufficient to assign a more specific code (e.g., bucket handle, peripheral). "Other" [forms] would be used when the information in the medical record provides detail for which a specific code does not exist.

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
836.0	Tear of medial cartilage or meniscus of knee, current	S83.2Ø6A	Unspecified tear of unspecified meniscus, current injury, right knee, initial encounter
719.06	Effusion, knee	M25.461	Effusion, knee, right

Other Impacts

S83.2Ø6 has a 7th character based on initial encounter, subsequent encounter, or sequela.

This injury code will continue to be coded until the condition is totally resolved without any sequela. When the patient returns for follow up the 7th character changes.

The 7th character definitions for this category are:

- **A – Initial encounter for injury**
  Examples of active treatment are:
  - surgical treatment,
  - emergency department encounter, and
  - evaluation and treatment by a new physician.

- **D – Subsequent encounter for injury with routine healing**
  Examples of subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
  Examples of subsequent care are:
  - cast change or removal,
  - removal of external or internal fixation device,
  - medication adjustment,
  - other aftercare and follow up visits following treatment of the injury or condition.

- **S – Sequela**
  "S" is for use for complications or conditions that arise as a direct result of a condition. When using 7th character "S", it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The "S" is added only to the injury code, not the sequela code. The 7th character "S" identifies the injury responsible for the sequela. The specific type of sequela (e.g. contracture after fracture) is sequenced first, followed by the injury code.

Scenario: Cervical Disc Disease

Scenario Details

Chief Complaint

- "My neck hurts and I have a tingling pain sensation going down my right arm."

History

- Patient is a 68 year-old male with history of neck pain that has been worsening over the last two years. Recently, he has experienced some numbness and a painful tingling sensation in his right arm going down to his thumb. No other symptoms or pertinent medical history.

Review of Systems, Physical Exam, Laboratory Tests

- Review of systems is negative except for the neck pain and sensations in his right arm described above. No history of acute injury to neck or arm.
- Physical exam is normal except for neurological exam of the right upper extremity, which reveals slight decrease to sensation in the thumb and forefinger region of the hand in the C6 nerve root distribution. No evidence of weakness in the muscles of the arm or hand.
- MRI scan of the neck shows degenerative changes of the C5-6 disc with lateral protrusion of disc material. No other abnormalities noted.

Assessment and Plan

- Cervical transforaminal injection at C5-6

Summary of ICD-10-CM Impacts

Clinical Documentation

- Subcategory M50.1 describes cervical disc disorders. M50.12 Cervical disc disease that includes degeneration of the disc as a combination code. The 5th character differentiates various regions of the cervical spine (high cervical C2-3 and C3-4; mid-cervical C4-5, C5-6, and C6-7; cervicothoracic C7-T1 and the associated radiculopathies at each level). This is a combination code that includes the disc degeneration and radiculopathy

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
722.0	Cervical disc displacement without myelopathy	M50.12	Cervical disc disorder with radiculopathy, mid-cervical region
722.4	Degeneration of cervical intervertebral disc		

Scenario: Struck by Car

Scenario Details

Chief Complaint

- "I was crossing the street and got hit by a car. My right leg is broken and my left wrist hurts."

History

- Patient is a 24-year-old male brought to the Emergency Department after being struck by a car while crossing the street. He denies any previous medical diseases or surgical procedures.

Review of Systems, Physical Exam, Laboratory Tests

VSS and Physical Exam are within normal limits with the following exceptions:

- RLE: open fracture of the mid-shaft region of the femur. Wound is approximately 15 cm in length and the bone fragments show injury to bone and periosteum (Gustilo Type IIIB); at least three fragments are visible. No apparent nerve or vascular injuries are noted.
- LUE: skin intact over entire extremity. There is obvious deformity of the wrist, which is painful to palpation. Neurological and vascular exam of the hand is intact.
- X-rays: comminuted mid-shaft fracture of the right femur. There is a transverse fracture of the distal left radius just proximal to the wrist joint with dorsal displacement of the distal fragment (Colles' fracture). All other x-rays are normal.

Hospital Course

- The patient was admitted to the hospital and taken directly to the operating room for initial treatment, including debridement and irrigation of the right open fracture and splinting of the left wrist. On the second hospital day, the patient was again taken to the operating room for definitive treatment of the both fractures by open reduction and internal fixation (ORIF) techniques.

Assessment and Plan

- Open comminuted fracture of the right femur, mid-shaft treated by ORIF
- Closed transverse fracture of the distal left radius treated by ORIF
- Injuries caused by vehicle-pedestrian accident

Summary of ICD-10-CM Impacts

Clinical Documentation

- When one or more fractures occur and different surgical procedures are performed, all of the first procedures are coded as initial encounter. The 7th character is not influenced by the order of the surgical procedures.
- When multiple surgical procedures are performed, although the codes for each injury are different, the reason is the same. In this case, the fracture of the femur and wrist were both caused by being hit by a car.
- Surgical treatment is considered "active" treatment or initial treatment even if it is not the first surgical procedure for the injury being treated.
- Open fractures are classified by their Gustillo type with 7th characters specific to type I, II, IIIA, IIIB or IIIC.
- The definitions of initial and subsequent are found in Volume 2 guidelines under Chapter 19.

Scenario: Struck by Car (continued)

7th character "A", initial encounter is used while the patient is receiving active treatment for the condition.
Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician.

7th character "D" subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
Examples of subsequent care are: cast change or removal, an x-ray to check healing status of fracture, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.

- The ICD-10 code V03.10xA illustrates the use of placeholder "x" when a 7th character is required, but the code only progresses to a 5th character level. In this example then the "x" placeholder is put into character space position 6 and then the 7th character for episode is added last.

In the chart you can see the possibilities of coding future encounters for this injury:

Injury Code	External Cause Code
S72.351**C** Fracture, comminuted shaft of femur, **initial encounter** for treatment of **open fracture type IIIB**	V03.10x**A** Pedestrian, on foot, injured in collision with car, pick-up truck, or van in traffic accident, **initial encounter**
S72.351**F** Fracture, comminuted shaft of femur, **subsequent** encounter for treatment of open fracture type IIIB **with routine healing**	V03.10x**D** Pedestrian, on foot, injured in collision with car, pick-up truck, or van in traffic accident, **subsequent encounter**
S72.351**N** Fracture, comminuted shaft of femur, **subsequent** encounter for treatment of open fracture type IIIB with **nonunion**	V03.10x**S** Pedestrian, on foot, injured in collision with car, pick-up truck, or van in traffic accident, **sequela**

Scenario: Struck by Car (continued)

- Report the external cause codes in ICD-10-CM.
  Include when documented:
  - The external cause for the codes
  - What the person was doing when they were injured (when documented)
  - Location of the accident (when documented)
  - The status of the patient such as student, volunteer, at work, and etc. (when documented)

The "how it happened" external cause code should never be a first-listed code on a claim.
This code should be used on all additional claims for this injury following the same guideline for the 7th character with the same definition of initial versus subsequent or sequela.

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
821.11	Fracture, open shaft of femur	S72.351C	Fracture, comminuted shaft of femur, initial encounter for treatment of open fracture type IIIB
813.41	Fracture, Colles'	S52.532A	Colles' fracture of left radius, initial encounter for closed fracture
E18.7	Accident, Motor vehicle involving collision with pedestrian injuring pedestrian	V03.10xA	Pedestrian, on foot, injured in collision with car, pick-up truck, or van in traffic accident, initial encounter
E849.5	Accident, occurring in street	Y92.410	Unspecified street and highway as the place of occurrence of the external cause

Scenario: Fracture

Scenario Details

Chief Complaint

- "I fell and hurt my right hip."

History

- Patient is a 74-year-old male who tripped over a rug at home, fell and had immediate pain in his right hip. He was transported to the Emergency Department by ambulance. In addition to his hip pain, he has a history of high blood pressure currently treated with Zaroxolyn and Lisonopril. He admits that he has been in the habit of cutting his BP pills in half to save money on refills. He also has a history of a myocardial infarction several years ago without any current manifestations.

Review of Systems, Physical Exam, Laboratory Tests

- Patient denies any symptoms other than hip pain; specifically denies any recent history of chest pain, arm pain, epigastric pain or shortness of breath
- BP on admission to the ED: 180/95
- X-ray: Right intertrochanteric hip fracture; no evidence of other bony injury
- EKG: evidence of old myocardial infarction; no evidence of recent myocardial injury

Treatment in ED

- Patient given IV medications for pain (morphine 1-2 mg IV titrated for relief)
- BP after IV medication: 165/90

Assessment and Plan

- Admit to hospital
- NS IV at 75 cc/hour
- Pain medications: morphine 1-2 mg IV prn
- NPO for surgery
- Orthopedic surgery and anesthesia consults

Summary of ICD-10-CM Impacts

Clinical Documentation

- Coding fractures as specifically as possible code to location, left versus right, and displaced or non-displaced, open or closed (7th character) and initial, subsequent, or sequela (7th character)
- NOTE that for S72 codes there are 16 different letters for the 7th character. Not only are they divided by type of encounter, but also open or closed, healing, non-union and type of open or closed fracture. Therefore, subsequent encounters may be any of the following codes for a closed fracture:
  - S72.141G (Closed, delayed healing)
  - S72.141K (Closed, non-union)
  - S72.141P (Closed mal-union)

Scenario: Fracture (continued)

Fracture Code for Subsequent Encounters	External Cause Code
S72.141**G** Displaced fracture, right femur, closed fracture **delayed healing**	W18.09x**D** Striking against other object with subsequent fall, **subsequent encounter**
S72.141**K** Displaced fracture, right femur, closed fracture with **nonunion**	W18.09x**S** Striking against other object with subsequent fall, **sequela encounter**
S72.141**P** Displaced fracture, right femur, closed fracture with **malunion**	W18.09x**S** Striking against other object with subsequent fall, **sequela encounter**

- Coding the mechanism of injury and place where the injury occurred from Index of External Causes that is found in Volume 3. In this index the key word is "Fall" is how the accident happened. These accident codes will always have a 7th character that refers to an initial, subsequent, or sequela encounter.

- This accident code will align with the actual injury code until resolved. The 7th character will then in subsequent encounters change to "subsequent" or "sequela" depending on the documentation in subsequent encounters. The "how it happened" external cause code should never be a first-listed code on a claim per ICD-10-CM coding guidelines.

Example:

Injury Code	External Cause Code
S72.141**A** Displaced fracture, right femur, **initial encounter**	W18.09x**A** Striking against other object with subsequent fall, **initial encounter**
S72.141**D** Displaced fracture, right femur, **subsequent encounter**	W18.09x**D** Striking against other object with subsequent fall, **subsequent encounter**
S72.141**S** Displaced fracture, right femur, **sequela encounter**	W18.09x**S** Striking against other object with subsequent fall, **sequela encounter**

Scenario: Fracture (continued)

- The code W18.09xD should be used on all additional claims for this injury following the same guideline for the 7th character with the same definition of initial versus subsequent or sequela.
- **Additional external cause codes should be used when documented for:**
    - What the person was doing when they were injured (when documented)
    - Location of the accident (when documented)
    - The status of the patient such as student, volunteer, at work, and etc. (when documented)
- Coding relevant co-morbid conditions such as patient's HTN
- Coding medication non-compliance (underdosing) from the Table of Drugs & Chemicals found in Volume 3. Go to the Table and along the left hand side located the drug name and if drug name is not found then search for the drug class. Then move across the columns to "underdosing" column. Move to the Tabular List (Volume 1) for the 7th character for initial, subsequent or sequela. The 7th character is found at the beginning of the category T46 and T50.
- Each medication that was under-dosed should be coded separately in ICD-10-CM.
- Use adjunct Z code for intentional underdosing after the underdosing as it is included in the documentation. The instruction for the use of these Z codes are found in the Tabular List (Volume 1) at the beginning of the poisoning, adverse effect and underdosing section above code T36.
- See the snapshot photo of this instruction below next to "**Use additional** code (s) to specify"

Scenario: Fracture (continued)

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
820.21	Femur fracture, closed, intertrochanteric section	S72.141A	Displaced intertrochanteric fracture of the right femur, initial encounter for a closed fracture (Note: fractures not indicated as displaced or non-displaced are coded as displaced; fractures not indicated as open or closed are coded as closed) (See note below S72 category in the Tabular List of ICD-10-CM)
E885.9	Fall from other slipping, tripping or stumbling	W18.09xA	Striking against other object with subsequent fall, initial encounter
E849.0	Accident occurring at home	Y92.009	Unspecified place in unspecified non-institutional (private) residence as the place of occurrence of the external cause
401.9	Essential hypertension, unspecified	I10	Hypertension
412	Old myocardial infarction	I25.2	Old myocardial infarction
No code available		T46.4x6A	Underdosing of angiotensin-converting-enzyme inhibitors, initial encounter
No code available		T50.2x6A	Underdosing of carbonic-anhydrase inhibitors, benzothiadiazides and other diuretics, initial encounter
V15.81	History of non-compliance with treatment	Z91.120	Intentional under dosing of medication regimen due to financial hardship

Other Impacts

ICD-10 has under-dosing code with each drug coded separately while ICD-0-CM does not have underdosing codes.