Q. Is the Deadline to ICD-10 based on Date of Service or Claim Submission Date? For example, if the patient was treated on Sept 30, 2015 but isn’t billed out Oct 5, 2015, do we still use ICD-10?

A. The ICD-10 conversion deadline is by Date of Service NOT claim Submission Date. So in the scenario listed above the claim would be submitted using ICD-9 since the date of service was prior to October 1, 2015.

Q. We noticed there is no code for facet syndrome, lumbar or cervical. We treat that a lot in this office, especially for our younger athlete patients. Could you please comment on that.

A. In my opinion it would fall in the other specified dorsopathy category M53.8x So cervical facet syndrome, if not further delineated by the provider would be reported with M53.82 lumbar facet syndrome could be coded as M53.86

Q. We noticed there is no code for deconditioning syndrome, we also use that in our rehab/PT department. Could you comment on that as well. I need more information on this diagnosis as it could be many potential diagnoses –

A. Are you currently using 728.2 - Muscular wasting and disuse atrophy not elsewhere classified? If so the general equivalent code is M62.50 Muscle wasting and atrophy, not elsewhere classified, unspecified site

Q. Osteoarthritis of the spine - that was a code that we used in our PT department.

A. Look at Category M47 (Spondylosis) which includes “arthrosis or osteoarthritis of the spine.” You will of course have to pick the specific site and type as M47 is only a category and not a valid code – e.g. M47.11 would be “Other spondylosis with myelopathy, occipito-atlanto-axial region” which includes osteoarthritis of the occipito-atlanto-axial region without myelopathy.

Q. For chiropractic; which code is proper for the subluxation code Cervical Segmental Dysfunction M99.01 or Cervical Subluxation M99.11?

A. M99.01. In ICD-10 “Subluxation Complex”, as defined by M99.01, is a Medical term not a Chiropractic one.
Q. For S13.100A thru S34.4XXA (Subluxation/Dislocation of XX, initial encounter). They are listed under Group D Diagnosis (30 visits/year), but they clearly state INITIAL ENCOUNTER, so can we only bill them once per onset date?

A. As a Chiropractor, you should always be using the “A” as the seventh character (when the code requires the seventh character for a specific ICD-10 code) for Medicare claims as the “A” indicates initial encounter / “Active Treatment” and most LCD’s only lists those as valid ICD-10 codes. I would not use “D” unless a payer requires it. To help with this explanation, below are the definitions of A, D and S:

- **A** – initial encounter, while patient is receiving active treatment such as surgery, ER, or evaluation and treatment by a new physician
- **D** – subsequent encounter, routine care during the healing or recovery phase, such as cast change, medication adjustment, aftercare and follow up
- **S** – sequela, complications or conditions that arise as a direct result of a condition, (perhaps degenerative disc disease a year after a neck sprain?). Sequela code (i.e. DDD) is first, then the injury code with the “S” on the end.

Q. How do we show laterality? I know 1=right 2=left, but at what digit - for example in codes for cervical sprain/strain S13.8xxA or S16.1xxA would it be the 5th or 6th place holder.

A. You cannot show laterality for the above codes, not all codes include laterality.

Q. If it is bilateral do we use 2 Diagnosis codes, one for right and one for left or just leave as S13.8xxA.

A. These codes are not bilateral so leave it.

Q. Both cervical and lumbar have a diagnosis for sprain and strain, the thoracic region only has diagnosis S23.3xxA for sprain. Is there not a diagnosis for thoracic strain?

A. Go to injuries of muscle tendon and fascia and choose muscle the group, you may want to consider strain of the muscle and tendon of back wall of the thorax S29.012A.

Q. Which are the correct subluxation codes that we are to use for Medicare and we should NOT be using the unspecified codes on the DX list?

A. The correct subluxation codes are the M99.01-M99.05 codes (Somatic and Segmental dysfunction). Make sure and pull the LCD at the Medicare Coverage Database to review the final LCD.

Q. Now that ICD 10 is coming, if the doctor adjusts extremities, does it have to correlate with spine? What other justification does billing for adjusting extremities require in the ICD-10?
A. ICD-10 does not change the requirements for CPT codes including 98943. To do an extremity adjustment you do not have to correlate the condition back to the spine (unless your State scope of practice requires it) however you do need to make sure that the patient complaints and diagnosis are consistent and support extraspinal adjustment.

Q. Do you know if there are going to be any Medicare diagnosis code order rules with ICD-10? Like you know how ICD-9 you need to have a subluxation as a primary diagnosis code in position 1 for Medicare or it will deny?

A. Medicare rules for diagnosis coding does not change, just the codes themselves. In other words, you should use ICD-10 codes for Medicare the exact same way you used ICD-9. Go to the Medicare Coverage Database and pull up your Local Coverage Documentation LCD for your state. This will detail the necessary rules. [https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx)

Q. If APS is set up to accommodate for ICD 10 with notes and we have all the payers for work comp and personal injury claims in the system entered. Do I have to contact each major insurance company (example, Progressive, State Farm) to inquire about claims submission in October?

A. It depends on the state so you should contact them to be sure as each payer and each state COULD have different rules in regards to ICD-10. PI and Workers’ Compensation payers do not have to use ICD-10 however many are making the change anyway.

Q. Cervical Radiculopathy, in ICD 9 it is 723.4 in ICD 10 - M54.12. We can't find, in the book mentioned above, a code to distinguish between Right or Left. Is there one? If so, what? Are there distinguishing codes for right or left for any radiculopathy?

A. No there are no codes representing laterality for radiculopathy, only regions of the spine

Q. G54.0 (TOS) Can you specify right or left by using a 1 or 2 at the end of the code?

A. No, G54.0 is a complete code. Left and right will be specified in the tabular listing if it is not specified then it is not required. Also, remember, PayDC only allows you to use valid and complete codes so you can inadvertently add on additional digits.

Q. Are there any strain codes, or now only sprains? For instance thoracic strain we cannot seem to find a code for that.

A. There are “strain” codes however the wording/definition may be different. For example: Go to injuries of muscle tendon and fascia and choose muscle the group, you may want to consider strain of the muscle and tendon of back wall of the thorax S29.012A.
Q. Our book is saying facet syndrome is now panniculitis? Is there a code specifically for facet syndrome?

You could use panniculitis however M54.0 is more of a soft tissue type injury. Instead it probably would fall in the other specified dorsopathy category M53.8x. Example, cervical facet syndrome, if not further delineated by the provider would be reported with M53.82 lumbar facet syndrome could be coded as M53.86

Q. I cannot find a code for muscle spasm other than cramp and spasm which we found to be R25.2.

A. Did you use the GEMS? If you look up 728.85 the GEMs point to M62.40 and M62.838

Q. The code for Sacroiliitis in ICD-10 states it as Sacroiliitis, not elsewhere otherwise classified. Is there a more appropriate code to use for Sacroiliitis?

A. No M46.1 Sacroiliitis, not elsewhere classified is a billable code and correct, unless you feel it is more of an SI joint sprain then you would look to S33.6

Q. Do we now have to code the specific rotator cuff ligament that is either partially torn or completely torn? If the specific ligament is not listed, is there an appropriate code we should be using for this?

A. Not all ligaments are listed in ICD-10 so use the code that includes rotator cuff tear. Go to M75.1 and look at the codes for complete and incomplete tear. Also note these are for a non-traumatic injury. For Traumatic injuries look at Excludes1 as well. Don’t forget to use your GEM’s

Q. I cannot find a code for a SLAP lesion or tear which in ICD9 was coded as 840.7.

A. Look at S43.43 _ Superior glenoid labrum lesion. This subcategory includes “SLAP” tears. Please note, this code is not included in the ChiroCode Book.

Q. We have not been able to find the diagnosis that shows laterality of TOS, brachial radiculitis, lumbar radiculitis (yet sciatica does) nor have we found a Dx showing laterality involving extremities such as shoulder or hip spr/str. Is that correct?

A. In regards to your first question, there are no codes representing laterality for radiculopathy, only regions of the spine. In regards to your second question, there is definitely laterality of a Hip Sprain, see S73.102 _ Unspecified sprain of left hip.
Q. For Medicare, what should I do if my claim is rejected? Will I know whether it was rejected because it is not a valid code versus denied due to a lack of specificity required for a Local Coverage Determination (LCD) or other claim edit?

A. Yes, submitters will know that it was rejected because it was not a valid code versus a denial for lack of specificity required for a LCD or other claim edit. Submitters should follow existing procedures for correcting and resubmitting rejected claims and issues related to denied claims.

Q. Is there a differentiation in the Cervicalgia diagnosis between left and right side?

A. No, there is only one code for Cervicalgia, M54.2

Q. Do you absolutely HAVE to have an "A" in every first visit for a Medicare patient? If you do that, do you have to have that "A" in EVERY diagnosis in every code?

A. Only certain codes/chapters (e.g. Chapter 19 for Acute Injuries – Sprains and Strains are coded here) require the seventh character designation A, D and S. If you are using one of those codes for Medicare, yes, you should always use an A as the seventh character if you are a chiropractor. Other disciplines may have different rules, e.g. the APTA states that PT’s should use the “D” in most cases.

If you have a Chronic Medicare patient, on the first visit, do you still need an "A" for the 7th character?

A. Yes