ICD-10 The Nuts and Bolts

On Behalf Of:
Association of New Jersey Chiropractors

Presented by:
David Klein CPC, CHC,
THIS PRESENTATION WAS CREATED IN ORDER TO HELP HEALTH CARE PROFESSIONALS, MEDICAL BILLING PERSONNEL, CODERS AND OTHER SUPPORT PERSONNEL TO BETTER UNDERSTAND THE RAPIDLY CHANGING MEDICAL/HEALTHCARE ENVIRONMENT. DOCUMENTATION, BILLING AND CODING DECISIONS SHOULD NOT BE SOLEY BASED UPON INFORMATION CONTAINED IN THIS PRESENTATION. INDIVIDUAL CIRCUMSTANCES, LEGAL AND ETHICAL CONSIDERATIONS AS WELL AS PAYER POLICIES SHOULD ALWAYS BE CONSIDERED WHEN DETERMINING A PARTICULAR COURSE OF ACTION. THIS PRESENTATION AND CONTENTS HERIN SHALL NOT BE CONSTRUED AS LEGAL ADVICE NOR AS ESTABLISHING A CLIENT-ATTORNEY RELATIONSHIP. RESOURCES ARE PROVIDED FOR EDUCATIONAL AND AWARENESS PURPOSES ONLY, AND AS SUCH, ARE PROVIDED STRICTLY AS SAMPLES. IF YOU HAVE QUESTIONS OF A LEGAL NATURE, YOU SHOULD CONTACT AN ATTORNEY AT LAW. THE PRESENTER MAKES NO WARRANTIES, EXPRESS OR IMPLIED, REGARDING ANY SUCH RESOURCES.
Recap
Recommended Tools

You could also use the complete code set (~68,000 codes), available from multiple publishers
ChiroCode Complete and Easy
ICD-10 Coding for Chiropractic

Pages 1-43: Complete guide to understanding ICD-10-CM coding
Pages 44-56: Commonly Used Codes*
Pages 57-134: Code Map (GEMs)*
Pages 135-454: Tabular list (abridged)
Pages 455-472: Alphabetic Index*
Pages 473-511: Coding Guidelines

*We’ll discuss these at length later
Direct ICD-9-CM to ICD-10-CM
Real Comparison

**ICD-9-CM**

728.85 - Spasm of muscle

**ICD-10-CM**

M62.40 CONTRACTURE OF MUSCLE UNSPECIFIED SITE
M62.411 CONTRACTURE OF MUSCLE RIGHT SHOULDER
M62.412 CONTRACTURE OF MUSCLE LEFT SHOULDER
M62.419 CONTRACTURE OF MUSCLE UNSPECIFIED SHOULDER
M62.421 CONTRACTURE OF MUSCLE RIGHT UPPER ARM
M62.422 CONTRACTURE OF MUSCLE LEFT UPPER ARM
M62.429 CONTRACTURE OF MUSCLE UNSPECIFIED UPPER ARM
M62.431 CONTRACTURE OF MUSCLE RIGHT FOREARM
M62.432 CONTRACTURE OF MUSCLE LEFT FOREARM
M62.439 CONTRACTURE OF MUSCLE UNSPECIFIED FOREARM
M62.441 CONTRACTURE OF MUSCLE RIGHT HAND
M62.442 CONTRACTURE OF MUSCLE LEFT HAND
M62.449 CONTRACTURE OF MUSCLE UNSPECIFIED HAND
M62.451 CONTRACTURE OF MUSCLE RIGHT THIGH
M62.452 CONTRACTURE OF MUSCLE LEFT THIGH
M62.459 CONTRACTURE OF MUSCLE UNSPECIFIED THIGH
M62.461 CONTRACTURE OF MUSCLE RIGHT LOWER LEG
M62.462 CONTRACTURE OF MUSCLE LEFT LOWER LEG
M62.469 CONTRACTURE OF MUSCLE UNSPECIFIED LEG
M62.471 CONTRACTURE OF MUSCLE RIGHT ANKLE AND FOOT
M62.472 CONTRACTURE OF MUSCLE LEFT ANKLE AND FOOT
M62.479 CONTRACTURE OF MUSCLE UNSPECIFIED ANKLE AND FOOT
M62.48 CONTRACTURE OF MUSCLE OTHER SITE
M62.49 CONTRACTURE OF MUSCLE MULTIPLE SITES
M62.830 MUSCLE SPASM OF BACK
M62.831 MUSCLE SPASM OF CALF
M62.838 OTHER MUSCLE SPASM
Important Conventions

General coding guidelines

- ICD-10-CM codes should be listed at their highest level of specificity and characters.
  
  a. Use three digit codes only if there are no four digit codes within the coding category. These are the heading of a category of codes.

  b. Use the 4, 5, 6, or 7 digit code to the greatest degree of specificity available. These provide further detail.
Important Conventions

“Excludes”

Excludes1 – consider these codes instead
(you can only use 1)
(mutually exclusive)

Excludes2 – consider these codes in addition
(you may use 2 or more)
(Not included)
DISLOCATION AND SPRAIN OF JOINTS AND LIGAMENTS OF LUMBAR SPINE AND PELVIS

**Includes:**
- avulsion of joint or ligament of lumbar spine and pelvis
- laceration of cartilage, joint or ligament of lumbar spine and pelvis
- sprain of cartilage, joint or ligament of lumbar spine and pelvis
- traumatic hemorrhosis of joint or ligament of lumbar spine and pelvis
- traumatic rupture of joint or ligament of lumbar spine and pelvis
- traumatic subluxation of joint or ligament of lumbar spine and pelvis
- traumatic tear of joint or ligament of lumbar spine and pelvis

**Excludes1:**
- nontraumatic rupture or displacement of lumbar intervertebral disc NOS (M51.-)
- obstetric damage to pelvic joints and ligaments (O71.6)

**Excludes2:**
- dislocation and sprain of joints and ligaments of hip (S73.-)
- strain of muscle of lower back and pelvis (S39.01-)

**Code also** any associated open wound
Important Conventions

“Do not code diagnoses documented as ‘probable’, ‘suspected’, ‘questionable’, ‘rule out’, or ‘working diagnosis’ or other similar terms indicating uncertainty.” (section IV.I)
A combination code is a single code used to classify:

• Two diagnoses, or
• A diagnosis with an associated secondary process (manifestation)
• A diagnosis with an associated complication
Important Conventions

- If the condition is bilateral and there is no bilateral code, then you have to list the left and right code separately.

- Sixth character (usually)
  - 1=right
  - 2=left

- List unspecified if laterality is not described
The seventh character (encounter):

- **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.
Important Conventions

Placeholder “x” character
ICD-10-CM utilizes a placeholder character “x” in positions 4, 5, and/or 6 in certain codes to allow for future expansion.

7th Characters
Certain ICD-10-CM categories have applicable 7th characters. The 7th character must *always* be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder “x” must be used to fill in the empty characters.
Important Conventions

- An unspecified code should be reported only when it is the code that most accurately reflects what is known about the patient’s condition at the time of that particular encounter.

*Note: payers are likely to deny unspecified codes*
ICD-10 Guidelines for DCs

1. Conventions
   (appendix, section I.A)
2. General Coding Guidelines
   (appendix, section I.B)
3. Chapter Specific Guidelines
   (appendix, section 1.C)
4. The Tabular List **takes precedence
   (in-column instructions)
Which guidelines do DCs need to know?

III. Tabular list
1. Infectious Diseases
2. Neoplasms
3. Blood
4. Endocrine
5. Mental
6. Nervous
7. Eye
8. Ear
9. Circulatory
10. Respiratory
11. Digestive
12. Skin
13. Musculoskeletal
14. Genitourinary
15. Pregnancy
16. Perinatal
17. Congenital malformations
18. Signs and Symptoms
19. Injuries and Poisoning
20. External Causes
21. Health Status
Which guidelines do DCs need to know?

Chapter 6: Guidelines for diseases of the nervous system (G00 – G99) (page 487)

Dominant or non-dominant side in hemiplegia (G81):
- For ambidexterous patients, default is dominant
- If the left side is affected, default is non-dominant
- If the right side is affected, default is dominant

Pain (G89 pain, not elsewhere classified)
- For generalized acute, chronic, post-thoracotomy, post-procedural, or neoplasm related.
  - Localized pain codes are found in other chapters (i.e. M54.9, back pain)
- G89 can be the principal diagnosis when it is reason for visit
Chapter 13: Guidelines for diseases of the musculoskeletal system and connective tissue

Site & laterality

- Site represents the bone, muscle, or joint involved
- Bone conditions occurring in a joint are classified by the bone involved, not the joint
- If a “multiple sites” code is available, use it instead of listing several sites individually

Acute traumatic versus chronic recurrent

- In general acute injury should be coded from chapter 19, recurrent or chronic conditions are coded from chapter 13
Which guidelines do DCs need to know?

Chapter 18: Guidelines for symptom, signs, and abnormal clinical findings, not elsewhere classified (R00 – R99) (page 491)

Use of symptom codes

- Acceptable when a definitive diagnosis has not been established by the provider

With a definitive diagnosis

- Only when the symptom is not routinely associated with the diagnosis

In a combination code

- Don’t code the symptom separately if it is part of a combination code
Chapter Specific Guidelines

A few examples from Chapter 18

- R07.1 Chest pain on breathing
- R07.82 Intercostal pain
- R10.83 Colic
- R11.0 Nausea
- R11.12 Projectile vomiting
- R20.1 Hypoesthesia of skin
- R26.2 Difficultly in walking, NEC
- R29.4 Clicking hip
- R42 Dizziness and giddiness
- R51 Headache
- R52 Pain, unspecified
- R60.0 Localized edema
- R68.84 Jaw pain
- R93.9 Diagnostic imaging inconclusive due to excess body fat of patient

Note: Do not code from this list. Use the tabular list to determine if one of these codes is appropriate.
Which guidelines do DCs need to know?

Chapter 19: Guidelines for injury, poisoning, and certain other consequences of external causes (S00 – T88) (page 492)

Injuries

- Code most serious injury first
- Superficial injuries are not coded with more serious injuries at the same site (such as contusions)
- Primary injury is first, then code for minor injury to nerves and blood vessels
- Pain due to medical devices would sequenced with a T code followed by G89.18 Other acute postprocedural pain or G89.28 Other chronic postprocedural pain
Which guidelines do DCs need to know?

Chapter 20: Guidelines for external causes of morbidity (V00 – Y99) (page 494)

Never sequenced first
Provide data about cause, intent, place, activity, or status of the accident or patient
No national requirement to use these codes, but voluntary reporting is encouraged

Y92 *Place of occurrence* should be listed after other codes, used only once at initial encounter, in conjunction with Y93

Y93 *Activity* code should be used only once, at initial encounter
How do I find the ICD-10 code?
Medicare LCD for ICD-9

Short term
- 306, 339, 784 Headaches
- 718 Contracture
- 721 Spondylosis
- 723-724 Back Pain

Moderate term
- 353 Root lesions
- 720 Enthesiopathy
- 722 Unspecified disc disorders
- 723 Other cervical disorders
- 724 Stenosis
- 729 Myalgia
- 738, 756 Spndylolisthesis
- 846-7 Sprains

Long term
- 721 Traumatic Spondylopathy
- 722 Degeneration, displaced discs
- 724 Sciatica
Medicare LCD for ICD-10

Short term

- G44 Headaches
- M24.5 Contracture
- M47 Spondylosis
- M48 DISH
- M54 Dorsalgia

Moderate term

- G54 Nerve root and plexus disorders
- M43 Spondylolisthesis
- M46 Spinal enthesiopathy
- M48 Spinal Stenosis
- M50, M51 Disc disorders
- M53 Other dorsopathies, NEC
- M54 Radiculopathies
- M60 Myositis
- M62 Spasm of back
- M79 Myalgia
- M99 Other biomechanical lesions

Long term

- M48 Traumatic spondylopathies
- M50 DDD
- M51 Disc displacement
- M54 Sciatica
- M96 Postlaminectomy

Note: These are only categories. To find the complete list, contact your CMS contractor or check the “Medicare Coverage Database”
How do I find the ICD-10 code?

Two Main Methods to Determine the Correct ICD-10 Code

1. GEMs code map, pages 57-133 (don’t stop here either!)
2. Alphabetic index, pages 455-472 (this is not safe either!)

Always confirm the code using the tabular list (pages 135-454).
How do I find the ICD-10 code?

General Equivalence Mappings (GEMs)
- Created by the National Center for Health Statistics, part of the CDC
- Forward maps from ICD-9 to ICD-10
- Backward maps from ICD-10 to ICD-9

- Download the free tablet/smartphone app called “FindACode”
- Use the Code Map section in the ChiroCode ICD-10 book (pages 57-133)
- ChiroCode members can access the MapACode tool in their accounts
1. GEMs

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>737</td>
<td>Curvature of spine</td>
<td>737.8</td>
<td>Other curvatures of spine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>737.9</td>
<td>Unspecified curvature of spine</td>
</tr>
<tr>
<td>738</td>
<td>OTHER ACQUIRED DEFORMITY</td>
<td>738.2</td>
<td>Acquired deformity of neck</td>
</tr>
<tr>
<td></td>
<td></td>
<td>738.3</td>
<td>Acquired deformity of chest and rib</td>
</tr>
<tr>
<td></td>
<td></td>
<td>738.4</td>
<td><strong>Acquired spondylolisthesis</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>738.5</td>
<td>Other acquired deformity of back or spine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>738.6</td>
<td>Acquired deformity of pelvis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>738.8</td>
<td>Acquired deformity of other specified site</td>
</tr>
<tr>
<td></td>
<td></td>
<td>738.9</td>
<td>Acquired deformity of unspecified site</td>
</tr>
<tr>
<td>739</td>
<td>NONALLOPATHIC LESIONS, NOT ELSEWHERE CLASSIFIED</td>
<td>739.0</td>
<td>Head region</td>
</tr>
<tr>
<td></td>
<td></td>
<td>739.1</td>
<td>Cervical region</td>
</tr>
<tr>
<td></td>
<td></td>
<td>739.2</td>
<td>Thoracic region</td>
</tr>
<tr>
<td></td>
<td></td>
<td>739.3</td>
<td>Lumbar region</td>
</tr>
</tbody>
</table>
2. Alphabetic index

unspecified, M99.9
related to use, overuse and pressure, M70

Somatoform disorders, F45
Spasmodic torticollis, G24.3
Spina bifida, Q05
    occulta, Q76.0

Spinal
    cord, other congenital malformations of, Q06
    enthesopathy, M46.0
    instabilities, M53.2
    muscular atrophy and related syndromes, G12
    osteochondrosis, M42
    stenosis, M48.0
Spondylitis, ankylosing, M45
Spondylolisthesis, M43.1
Spondylolysis, M43.0

Still’s disease
    NOS, M08.2
    adult-onset, M06.1

Strain - see injuries of, muscles, tendons, and fascia
Street, highway and other paved roadways as the place of occurrence of the external cause, Y92.4
Streptococcal arthritis and polyarthritis, M00.2
Stress fracture, M84.3
    of vertebra, M48.4
Striking against or struck by
    automobile airbag, W22.1
    other objects, W22
    other objects, W22
3. Tabular Listing

OTHER DEFORMING DORSOPATHIES

Excludes1:
- congenital spondylolysis and spondylolysis (Q76.2)
- hemivertebra (Q76.3-Q76.4)
- Klippel-Feil syndrome (Q76.1)
- laminarization and sacralization (Q76.4)
- platyspondylysis (Q76.4)
- spina bifida occulta (Q76.0)
- spinal curvature in osteoporosis (M80.-)
- spinal curvature in Paget’s disease of bone [ostitis deformans] (M88.-)

M43.0 Spondyloysis

Excludes1:
- congenital spondylolysis (Q76.2)
- spondylolysis (M43.1)

M43.00 Spondylysis, site unspecified
M43.01 Spondylysis, occipito-atlanto-axial region
M43.02 Spondylysis, cervical region
M43.03 Spondylysis, cervicothoracic region
M43.04 Spondylysis, thoracic region
M43.05 Spondylysis, thoracolumbar region
M43.06 Spondylysis, lumbar region
M43.07 Spondylysis, lumbosacral region
M43.08 Spondylysis, sacral and sacroccocygeal region
M43.09 Spondylysis, multiple sites in spine

M43.1 Spondylolisthesis

Excludes1:
- acute traumatic of lumbosacral region (S33.1)
- acute traumatic of sites other than lumbosacral- code to Fracture, vertebra, by region
congenital spondylolisthesis (Q76.2)

M43.10 Spondylolisthesis, site unspecified
M43.11 Spondylolisthesis, occipito-atlanto-axial region
M43.12 Spondylolisthesis, cervical region
M43.13 Spondylolisthesis, cervicothoracic region
M43.14 Spondylolisthesis, thoracic region
M43.15 Spondylolisthesis, thoracolumbar region
M43.16 Spondylolisthesis, lumbar region
M43.17 Spondylolisthesis, lumbosacral region
M43.18 Spondylolisthesis, sacral and sacroccocygeal region
M43.19 Spondylolisthesis, multiple sites in spine

M43.2 Fusion of spine

Ankylosis of spinal joint

Excludes1:
- ankylosing spondylitis (M45.-)
congenital fusion of spine (Q76.4)

Excludes2:
- arthrodesis status (Z98.1)
pseudoarthrosis after fusion or arthrodesis (M96.0)

M43.20 Fusion of spine, site unspecified
M43.21 Fusion of spine, occipito-atlanto-axial region
M43.22 Fusion of spine, cervical region
How do I code for a subluxation?

739.1 Nonallopathic lesions, Not Elsewhere Classified; cervical region, cervicothoracic region

Includes “Somatic and segmental dysfunction”

Note: The word “subluxation” does not appear in ICD-9-CM in the 739 codes.
How do I code for a subluxation?

739.1 Nonallopathic lesions, Not Elsewhere Classified; cervical region, cervicothoracic region

Using GEMs / code map (page 96), we find:

**M99.01 Biomechanical lesions, Not Elsewhere Classified; segmental and somatic dysfunction of cervical region**

Note: Still no mention of the “subluxation”
How do I code for a subluxation?

739.1 Nonallopathic lesions, Not Elsewhere Classified; cervical region, cervicothoracic region

Using the tabular list (page 252), we find:

**M99.11 Subluxation complex (vertebral) of cervical region**

Note: this code maps back to 839, not 739
How do I code for a subluxation?

739.1 Nonallopatiche lesions, Not Elsewhere Classified; cervical region, cervicothoracic region

Using the alphabetic index (Subluxation and dislocation → cervical vertebrae) we find:

S13.1__ subluxation and dislocation of cervical vertebrae

Still 54 possible combinations!

Note: These codes all map back to 839 codes in ICD-9
How do I code for a subluxation?

Fifth character gives the specific vertebral level:

S13.10  _  Subluxation and dislocation of unspecified cervical vertebrae
S13.11  _  Subluxation and dislocation of C0/C1 cervical vertebrae
S13.12  _  Subluxation and dislocation of C1/C2 cervical vertebrae
S13.13  _  Subluxation and dislocation of C2/C3 cervical vertebrae
S13.14  _  Subluxation and dislocation of C3/C4 cervical vertebrae
S13.15  _  Subluxation and dislocation of C4/C5 cervical vertebrae
S13.16  _  Subluxation and dislocation of C5/C6 cervical vertebrae
S13.17  _  Subluxation and dislocation of C6/C7 cervical vertebrae
S13.18  _  Subluxation and dislocation of C7/T1 cervical vertebrae
How do I code for a subluxation?

Sixth character differentiates between a subluxation and a dislocation:

0 = subluxation   1 = dislocation

S13.110_ **Subluxation of C0/C1 cervical vertebrae**
S13.111_ **Dislocation of C0/C1 cervical vertebrae**
How do I code for a subluxation?

Seventh character identifies the encounter:

S13.110A  Subluxation of C0/C1 cervical vertebrae, initial encounter
S13.110D  Subluxation of C0/C1 cervical vertebrae, subsequent encounter
S13.110S  Subluxation of C0/C1 cervical vertebrae, sequela

Seventh character extension:
A= initial encounter: (i.e. active treatment - initial E/M visit)
D= subsequent encounter: (i.e. healing, recovery, aftercare, or follow-up)
S= sequela (complications as a result of an injury) (ex: scar due to burns)
How do I code for a subluxation?

739.1 Nonallopathic lesions, Not Elsewhere Classified; cervical region, cervicothoracic region

All of these options are listed in the “Commonly Used Codes for Chiropractic” (page 44) for the cervical region.

Be sure to confirm the code selected with the tabular list. Understand the guidelines and conventions.
How do I code for whiplash?

847.0: Sprain of neck
(includes strain of joint capsule, ligament, muscle, tendon)

Using the Alphabetic index (sprain of → spine → cervical) we find:
S13.4_ _ _ Sprain of ligaments of the cervical spine

Note that there must be seven characters for the code to be complete. (See page 279)
How do I code for whiplash?

847.0 Sprain of neck

Using GEMs / code map (page 124) we find:

S13.4xxA Sprain of ligaments of the cervical spine
S13.8xxA Sprain of joints and ligaments of other parts of the neck

This represents six possible codes, depending on the 7th character, or encounter (A: initial, D: subsequent, or S: sequela)
How do I code for whiplash?

847.0 *Sprain of neck*

*S13.4xxA* specifies the anterior longitudinal ligament, atlanto-axial joints, atlanto-occipital joints, and whiplash injury.

*S13.8xxA* just says “other parts of the neck”

Documentation should match these descriptions.
How do I code for whiplash?

847.0 *Sprain of neck*

Note the use of the placeholder “x”
Note the seventh character
Remember The Guidelines

The seventh character (encounter):

- **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.
How do I code for whiplash?

847.0 *Sprain of neck*

(includes strain of joint capsule, ligament, muscle, tendon)

Using the Alphabetic index (injury of muscle, fascia and tendon at neck level) we find:

**S16.1xxA  Strain of muscle, fascia and tendon at neck level, initial encounter**

Note: **S16.1xxA** maps backward to **847.0**
How do I code for DDD?

722.4 Degeneration of a cervical intervertebral disc

Using GEMs / code map, we find:
M50.30 Other cervical disc degeneration, unspecified cervical region

Unspecified codes should be avoided, if possible
How do I code for DDD?

722.4 Degeneration of a cervical intervertebral disc

On our own (page 219), we find:

M50.31 Other cervical disc degeneration, high cervical region
M50.32 Other cervical disc degeneration, mid-cervical region
M50.33 Other cervical disc degeneration, cervicothoracic region
How do I code for Knee Osteoarthritis?

715.16 - Osteoarthrosis, localized, primary, lower leg

Using The GEMS we find:

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
What does the documentation look like?

MEDICAL ALPHABET

A B C D E
F G H I J
K L M N O
P Q R S T
U V W X Y
Z
Codes must be supported by the documentation in the patient record.

The AAPC estimates an increase in documentation time of 15%.

The AAPC also found that 65% of physician notes were not specific enough.

Examples of details not necessary in ICD-9:
- side of dominance
- trimesters
- stages of healing
- laterality
- ordinality
- External Causes
Example

Migraines (page 149)

44 choices available for migraines

• Documentation must include:
  o With or without aura
  o Intractable or not intractable
  o With or without status migrainosus
  o Persistent or chronic
  o With or without vomiting
  o With or without ophthalmoplegic, menstrual, etc.
  o Induced by ICD-10 training
Case Study #1

Patient presents to discuss issues with Migraines which started about 1 year ago after a concussion. Headaches more frequent, also tired and nausea. Concussion about 1 year ago, brief LOC, first migraine 2 weeks later. Now having HA weekly and generalized. Also present are throbbing sensation, photophobia, nausea, worse when reclining, no change in vision, no numbness or weakness. Currently taking Tylenol with no relief. Aura presents about 30 minutes prior to onset of migraines with flashes of light. Migraine lasts 24 hours or less.

Family History

Positive for Diabetes.

Social History

Single, never smoker

Physical Exam:

General: pleasant WDWN female in NAD

Neuro: CN II-XII intact grossly, normal gait, MS 5/5, DTR 2+

MS: full AROM of C-spine

Skin: warm and dry

Impression:

Classical Migraine without status migrainosus
### Status Migrainosus? Intractable?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G43.101</td>
<td>Migraine with aura, not intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.109</td>
<td>Migraine with aura, not intractable, without status migrainosus</td>
</tr>
<tr>
<td>G43.11</td>
<td>Migraine with aura, intractable</td>
</tr>
<tr>
<td>G43.111</td>
<td>Migraine with aura, intractable, with refractory migraine</td>
</tr>
<tr>
<td>G43.119</td>
<td>Migraine with aura, intractable, without status migrainosus</td>
</tr>
<tr>
<td>G43.4</td>
<td>Hemiplegic migraine</td>
</tr>
<tr>
<td></td>
<td>Familial migraine</td>
</tr>
<tr>
<td></td>
<td>Sporadic migraine</td>
</tr>
<tr>
<td>G43.40</td>
<td>Hemiplegic migraine, not intractable</td>
</tr>
<tr>
<td></td>
<td>Hemiplegic migraine without refractory migraine</td>
</tr>
<tr>
<td>G43.401</td>
<td>Hemiplegic migraine, not intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.409</td>
<td>Hemiplegic migraine, not intractable, without status migrainosus</td>
</tr>
<tr>
<td></td>
<td>Hemiplegic migraine NOS</td>
</tr>
<tr>
<td>G43.41</td>
<td>Hemiplegic migraine, intractable</td>
</tr>
<tr>
<td></td>
<td>Hemiplegic migraine with refractory migraine</td>
</tr>
<tr>
<td>G43.411</td>
<td>Hemiplegic migraine, intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.419</td>
<td>Hemiplegic migraine, intractable, without status migrainosus</td>
</tr>
<tr>
<td>G43.5</td>
<td>Persistent migraine aura without cerebral infarction</td>
</tr>
<tr>
<td>G43.60</td>
<td>Persistent migraine aura with cerebral infarction, not intractable</td>
</tr>
<tr>
<td></td>
<td>Persistent migraine aura with cerebral infarction, without refractory migraine</td>
</tr>
<tr>
<td>G43.601</td>
<td>Persistent migraine aura with cerebral infarction, not intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.609</td>
<td>Persistent migraine aura with cerebral infarction, not intractable, without status migrainosus</td>
</tr>
<tr>
<td>G43.61</td>
<td>Persistent migraine aura with cerebral infarction, intractable</td>
</tr>
<tr>
<td></td>
<td>Persistent migraine aura with cerebral infarction, with refractory migraine</td>
</tr>
<tr>
<td>G43.611</td>
<td>Persistent migraine aura with cerebral infarction, intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.619</td>
<td>Persistent migraine aura with cerebral infarction, intractable, without status migrainosus</td>
</tr>
<tr>
<td>G43.7</td>
<td>Chronic migraine without aura</td>
</tr>
<tr>
<td></td>
<td>Transformed migraine</td>
</tr>
<tr>
<td></td>
<td>Excludes: Migraine without aura (G43.0)</td>
</tr>
<tr>
<td>G43.70</td>
<td>Chronic migraine without aura, not intractable</td>
</tr>
<tr>
<td></td>
<td>Chronic migraine without aura, without refractory migraine</td>
</tr>
<tr>
<td>G43.701</td>
<td>Chronic migraine without aura, not intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.709</td>
<td>Chronic migraine without aura, not intractable, without status migrainosus</td>
</tr>
<tr>
<td></td>
<td>Chronic migraine without aura NOS</td>
</tr>
<tr>
<td>G43.71</td>
<td>Chronic migraine without aura, intractable</td>
</tr>
</tbody>
</table>
Congenital anomalies of the spine may be simple (e.g., no spinal deformity) or complex (e.g., severe spinal deformity or paraplegia). The most common congenital spinal deformities are:

- Hyperlordosis
- Kyphosis
- Scoliosis

In ICD-9-CM, coders report 754.2 (certain congenital musculoskeletal deformities of the spine) to denote all three conditions.
What does the documentation look like?

In ICD-10 conditions such as kyphosis, are divided into separate code categories based on the specific location of the deformity.

- M40.00 Postural Kyphosis unspecified
- M40.03 Postural Kyphosis, cervicothoracic region
- M40.04 Postural Kyphosis, thoracic region
- M40.05 Postural Kyphosis, thoracolumbar region

Physicians must document the specific region involved, which is not something they currently do in ICD-9-CM.
Many ICD-10-CM codes are very specific in terms of anatomy and providers must document to this level of specificity. For example, degenerative changes of the spine (code M47 [spondylosis]) should document the exact level:

- Spondylosis (code M47-):
- Occipito-atlanto-axial
- Cervical
- Cervicothoracic
- Thoracic
- Thoracolumbar
- Lumbar
- Lumbosacral
- Sacral and sacrococcygeal

**Old final impression:** Degenerative changes.

**New final impression:** Degenerative changes along the lumbar spine

ICD-10: Code M47.816 (spondylosis without myelopathy or radiculopathy, lumbar region)
Laterality & Location

The codes for limb pain provide another great example. ICD-9-CM contains one code for limb pain (code 729.5), but for ICD-10-CM, we now have many locations and codes for limb pain:

- Right arm, Left arm
- Right leg, Left leg
- Right upper arm, Left upper arm
- Right forearm, Left forearm
- Right hand, Left hand
- Right fingers, Left fingers
- Right thigh, Left thigh
- Right lower leg, Left lower leg
- Right foot, Left foot
- Right toes, Left toes

**Example 1:**
*Clinical indication*: Right leg pain  - Code M79.604 (pain in right leg)

**Example 2:**
*Clinical indication*: Pain, right fingers  - Code M79.644 (pain in right finger[s])

**Note:** that these codes exclude joint pain, which is coded in the M25.5 range.
S: Mrs. Finley presents today after having a new cabinet fall on her last week, suffering a concussion, as well as some cervicalgia. She was cooking dinner at the home she shares with her husband. She states that the people that put in the cabinet in her kitchen missed the stud by about two inches. Her husband, who was home with her at the time told her she was “out cold” for about two minutes. The patient continues to have cephalgias since it happened, primarily occipital, extending up into the bilateral occipital and parietal regions. The headaches come on suddenly, last for long periods of time, and occur every day. They are not relieved by Advil. She denies any vision changes, any taste changes, any smell changes. The patient has a marked amount of tenderness across the superior trapezius.

O: Her weight is 188 which is up 5 pounds from last time, blood pressure 144/82, pulse rate 70, respirations are 18. She has full strength in her upper extremities. DTRs in the biceps and triceps are adequate. Grip strength is adequate. Heart rate is regular and lungs are clear.

A: Status post concussion with acute persistent headaches
Cervicalgia
Cervical somatic dysfunction

P: The plan at this time is to send her for physical therapy, three times a week for four weeks for cervical soft tissue muscle massage, as well as upper dorsal. We’ll recheck her in one month, sooner if needed.
What does the documentation look like?

- **S06.0x1A**  
  Concussion with loss of consciousness of 30 minutes or less, initial encounter

- **G44.311**  
  Acute post traumatic headache, intractable

- **M54.2**  
  Cervicalgia

- **M99.01**  
  Segmental and somatic dysfunction of cervical region

- **W20.8xxA**  
  Struck by falling object (accidentally), initial encounter

- **Y93.G3**  
  Activity, cooking and baking

- **Y92.010**  
  Place of occurrence, house, single family, kitchen

What does the documentation look like?

“Exam findings are consistent with cervical sprain/strain and acute cephalgia due to motor vehicle accident”

In ICD-9, the codes might be: (see workbook)

- 847.0 Cervical sprain
- 339.21 Acute post-traumatic headache
- E813.0 Motor vehicle traffic accident involving collision with other vehicle; driver of motor vehicle other than motorcycle injured
What does the documentation look like?

“Exam findings are consistent with cervical sprain/strain and acute cephalgia due to motor vehicle accident”

In ICD-9, the codes might be: (see workbook)

- 847.0 Cervical sprain
- 339.21 Acute post-traumatic headache
- E813.0 Motor vehicle traffic accident involving collision with other vehicle; driver of motor vehicle other than motorcycle injured
What does the documentation look like?

“Exam findings are consistent with cervical sprain/strain and acute cephalgia due to motor vehicle accident”

In ICD-9, the codes might be:

- **847.0 Cervical sprain**
- **339.21 Acute post-traumatic headache**
- **E813.0 Motor vehicle traffic accident involving collision with other vehicle; driver of motor vehicle other than motorcycle injured**
What does the documentation look like?

“Exam findings are consistent with cervical sprain/strain and acute cephalgia due to motor vehicle accident”

In ICD-9, the codes might be:
- 847.0 Cervical sprain

General Equivalence Mappings (free FindACode app) suggest the following codes:
- S13.4xxA Sprain of ligaments of the cervical spine, initial encounter
  OR
- S13.8xxA Sprain of other parts of the neck, initial encounter

Note: When you look up S13.4xxA in the tabular list, you will find which parts of the cervical spine it includes in the fine print. This is why you need a complete book, not just a short crosswalk list of codes.
What does the documentation look like?

“Exam findings are consistent with cervical sprain/strain and acute cephalgia due to motor vehicle accident”

In ICD-9, the codes might be:
- 847.0 Cervical sprain

If you knew to look up “injury of → muscle, fascia and tendon at → neck level” in the index you would also find:
- S16.1xxA Strain of muscles, fascia and tendon at neck level, initial encounter

Note: Sprain and strain are separate codes in ICD-10. Crosswalks won’t tell you about this code, you need to know how to use the alphabetic index.
What does the documentation look like?

“Exam findings are consistent with cervical sprain/strain and acute cephalgia due to motor vehicle accident”

In ICD-9, the codes might be:

- **847.0** Cervical sprain
- **339.21** Acute post-traumatic headache
- E813.0 Motor vehicle traffic accident involving collision with other vehicle; driver of motor vehicle other than motorcycle injured
What does the documentation look like?

“Exam findings are consistent with cervical sprain/strain and acute cephalgia due to motor vehicle accident”

In ICD-9, the codes might be:
- **339.21** Acute post-traumatic headache

GEMs suggest:
- **G44.319** Acute post-traumatic headache, not intractable

Note: In the index **G44.319** is next to **G44.311** which is the intractable version of this condition.
  - Intractable means “hard to control or deal with”
  - This must be documented in order to select the correct code.
“Exam findings are consistent with cervical sprain/strain and acute cephalgia due to motor vehicle accident”

In ICD-9, the codes might be:
- 847.0 Cervical sprain
- 339.21 Acute post-traumatic headache
- **E813.0 Motor vehicle traffic accident involving collision with other vehicle; driver of motor vehicle other than motorcycle injured**
What does the documentation look like?

“Exam findings are consistent with cervical sprain/strain and acute cephalgia due to motor vehicle accident”

In ICD-9, the codes might be:

- E813.0 Motor vehicle traffic accident involving collision with other vehicle; driver of motor vehicle other than motorcycle injured

Note: External cause codes describe location, circumstances, and causes of injury. More detail is needed since these codes are greatly expanded in ICD-10. (However, they are only required if you already use ICD-9 E-codes)
What does the documentation look like?

“What exam findings are consistent with strain and sprain of the ligaments and muscles of the cervical spine and acute traumatic headache, which does not respond to over the counter medications. Patient was the driver of a vehicle that collided with another motor vehicle on the interstate.

The ICD-10 codes in this case are:

- **S13.4xxA** Sprain of ligaments of the cervical spine, initial encounter
- **S16.1xxA** Strain of muscles, fascia and tendon at neck level, initial encounter
- **G44.311** Acute post-traumatic headache, intractable
- **V49.40xA** Driver injured in collision with unspecified motor vehicle, traffic accident, initial encounter
- **Y92.411** Interstate as place of occurrence of the external cause
What does the documentation look like?

“Exam findings are consistent with strain and sprain of the ligaments and muscles of the cervical spine and acute traumatic headache, which does not respond to over the counter medications. Patient was the driver of a vehicle that collided with another motor vehicle on the interstate.

The ICD-10 codes in this case are:
• **S13.4xxA Sprain of ligaments of the cervical spine, initial encounter**
• **S16.1xxA Strain of muscles, fascia and tendon at neck level, initial encounter**
• **G44.311 Acute post-traumatic headache, intractable**
• **V49.40xA Driver injured in collision with unspecified motor vehicle, traffic accident, initial encounter**
• **Y92.411 Interstate as place of occurrence of the external cause**
What does the documentation look like?

“Exam findings are consistent with strain and sprain of the ligaments and muscles of the cervical spine and acute traumatic headache, which does not respond to over the counter medications. Patient was the driver of a vehicle that collided with another motor vehicle on the interstate.

The ICD-10 codes in this case are:

- **S13.4xxA** Sprain of ligaments of the cervical spine, initial encounter
- **S16.1xxA** Strain of muscles, fascia and tendon at neck level, initial encounter
- **G44.311** Acute post-traumatic headache, intractable
- **V49.40xA** Driver injured in collision with unspecified motor vehicle, traffic accident, initial encounter
- **Y92.411** Interstate as place of occurrence of the external cause
What does the documentation look like?

“Exam findings are consistent with strain and sprain of the ligaments and muscles of the cervical spine and acute traumatic headache, which does not respond to over the counter medications. Patient was the driver of a vehicle that collided with another motor vehicle on the interstate.

The ICD-10 codes in this case are:

- **S13.4xxA** Sprain of ligaments of the cervical spine, initial encounter
- **S16.1xxA** Strain of muscles, fascia and tendon at neck level, initial encounter
- **G44.311** Acute post-traumatic headache, intractable
- **V49.40xA** Driver injured in collision with unspecified motor vehicle, traffic accident, initial encounter
- **Y92.411** Interstate as place of occurrence of the external cause
What does the documentation look like?

“Exam findings are consistent with strain and sprain of the ligaments and muscles of the cervical spine and acute traumatic headache, which does not respond to over the counter medications. Patient was the driver of a vehicle that collided with another motor vehicle on the interstate.

The ICD-10 codes in this case are:

• S13.4xxA Sprain of ligaments of the cervical spine, initial encounter
• S16.1xxA Strain of muscles, fascia and tendon at neck level, initial encounter
• G44.311 Acute post-traumatic headache, intractable
• V49.40xA Driver injured in collision with unspecified motor vehicle, traffic accident, initial encounter
• Y92.411 Interstate as place of occurrence of the external cause
What does the documentation look like?

“Exam findings are consistent with strain and sprain of the ligaments and muscles of the cervical spine and acute traumatic headache, which does not respond to over the counter medications. Patient was the driver of a vehicle that collided with another motor vehicle on the interstate.

The ICD-10 codes in this case are:

- **S13.4xxA** Sprain of ligaments of the cervical spine, initial encounter
- **S16.1xxA** Strain of muscles, fascia and tendon at neck level, initial encounter
- **G44.311** Acute post-traumatic headache, intractable
- **V49.40xA** Driver injured in collision with unspecified motor vehicle, traffic accident, initial encounter
- **Y92.411** Interstate as place of occurrence of the external cause
Case #2

Mr. Jones enters the office for the first time with complaints from an auto accident. The collision was traumatic. He was a passenger and was severely jolted by the crash and felt immediate low back pain on both sides and right hip pain. He also hit his right knee against the dashboard.

Assessment: lumbar muscle spasm, lumbar restriction, traumatic subluxation at L4-L5 & right SI joint, right knee red/swollen, right knee contusion.
Provided Diagnosis Codes

1. S33.5XXA - Sprain of ligaments of lumber spine
2. M54.5, Lumbago
3. M62.830, Muscle spasm of back
4. S33.140A, Subluxation of L4/L5 lumbar vertebra
5. M25.551, Pain in right hip
6. S73.011A, Posterior subluxation of right hip
7. M25.461, Effusion right knee
8. S80.01XA Contusion of right knee
How I would Code

Assessment: lumbar muscle spasm, lumbar restriction, traumatic subluxation at L4-L5 & right SI joint, right knee red/swollen, right knee contusion.

1. S33.140A, Subluxation of L4/L5 lumbar vertebra
2. S33.2XXA - Dislocation of scroiliac and sacrococcygeal joint.)
3. S80.01XA Contusion of right knee
4. M54.5, Lumbago
5. M25.551, Pain in right hip
6. M62.830, Muscle spasm of back

I would not code for S73.011A, Posterior subluxation of right hip as this was not stated. Also, Sprain of ligaments of lumber spine is not stated – also if i code this then shouldn’t I code for Sprain of the sacroiliac joint? S33.6XXA. Notably I would also document the collision and place of occurrence. This example in my opinion does not provide enough information to code correctly.
Additional Case Studies

Case #3

Mrs. Johnson presents with pain radiating from the left side of her lower neck down into her left arm and feels pins and needles in her left thumb and index finger. She also has left shoulder pain with stiffness. Assessment: segmental dysfunction (non-traumatic subluxation) at C5-6. X-rays reveal left shoulder osteoarthritis. MRI reveals C5-6 disc herniation.
Provided Diagnosis Codes

1. M50.12 - Cervical Disc disorder with radiculopathy, mid-cervical region
2. M54.2 - Cervicalgia
3. R20.2 – Parasthesia of skin (pins and needles
4. M99.01 – Segmental and somatic dysfunction of cervical region
5. M25.512 – Pain in left shoulder
6. M19.012 – Primary osteoarthritis, left shoulder
7. M25.612 - Stiffness left shoulder NEC
How I would Code

Mrs. Johnson presents with pain radiating from the left side of her lower neck down into her left arm and feels pins and needles in her left thumb and index finger. She also has left shoulder pain with stiffness. Assessment: segmental dysfunction (non-traumatic subluxation) at C5-6. X-rays reveal left shoulder osteoarthritis. MRI reveals C5-6 disc herniation.

1. M50.12 - Cervical Disc disorder with radiculopathy, mid-cervical region
2. M19.012 – Primary osteoarthritis, left shoulder
3. M99.01 – Segmental and somatic dysfunction of cervical region
4. M25.512 – Pain in left shoulder
5. M25.612 - Stiffness left shoulder NEC

I probably would not code for R20.2 – Parasthesia of skin / “Pins and needles” See next slide. Also M54.2 would not be coded as it is mutually exclusive to M50.12 (see Excludes1). Note – I would also change the order as Osteoarthritis is probably considered a more significant injury from a “payer” perspective.
“Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes” (section I.B.7)

Example: R68.84 Jaw pain would not be coded with
  o M26.62 temporomandibular joint arthralgia
To code for Scoliosis, what do you need to know to choose a code that is not unspecified?

Type of scoliosis (infantile, juvenile, adolescent, thoracogenic, neuromuscular, secondary), then location

A 13 year old is diagnosed with adolescent scoliosis. Cobb’s angle is 14 degrees at T10-L2. What is the ICD-10 code?

M41.125 Adolescent idiopathic scoliosis, thoracolumbar region
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M40.40</td>
<td>Postural lordosis, site unspecified</td>
</tr>
<tr>
<td>M40.45</td>
<td>Postural lordosis, thoracolumbar region</td>
</tr>
<tr>
<td>M40.46</td>
<td>Postural lordosis, lumbar region</td>
</tr>
<tr>
<td>M40.47</td>
<td>Postural lordosis, lumbosacral region</td>
</tr>
<tr>
<td>M40.5</td>
<td>Lordosis, unspecified</td>
</tr>
<tr>
<td>M40.50</td>
<td>Lordosis, unspecified, site unspecified</td>
</tr>
<tr>
<td>M40.55</td>
<td>Lordosis, unspecified, thoracolumbar region</td>
</tr>
<tr>
<td>M40.56</td>
<td>Lordosis, unspecified, lumbar region</td>
</tr>
<tr>
<td>M40.57</td>
<td>Lordosis, unspecified, lumbosacral region</td>
</tr>
</tbody>
</table>

**SCOLIOSIS**

Includes:
- kyphoscoliosis

Excludes:
- congenital scoliosis NOS (Q67.5)
- congenital scoliosis due to bony malformation (Q76.3)
- postural congenital scoliosis (Q67.5)
- kyphoscoliotic heart disease (I27.1)
- postprocedural scoliosis (M96.-)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M41.00</td>
<td>Infantile idiopathic scoliosis</td>
</tr>
<tr>
<td>M41.12</td>
<td>Adolescent scoliosis</td>
</tr>
<tr>
<td>M41.122</td>
<td>Adolescent idiopathic scoliosis, cervical region</td>
</tr>
<tr>
<td>M41.123</td>
<td>Adolescent idiopathic scoliosis, cervicothoracic region</td>
</tr>
<tr>
<td>M41.124</td>
<td>Adolescent idiopathic scoliosis, thoracic region</td>
</tr>
<tr>
<td>M41.125</td>
<td>Adolescent idiopathic scoliosis, thoracolumbar region</td>
</tr>
<tr>
<td>M41.126</td>
<td>Adolescent idiopathic scoliosis, lumbar region</td>
</tr>
<tr>
<td>M41.127</td>
<td>Adolescent idiopathic scoliosis, lumbosacral region</td>
</tr>
<tr>
<td>M41.129</td>
<td>Adolescent idiopathic scoliosis, site unspecified</td>
</tr>
</tbody>
</table>

**Other idiopathic scoliosis**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M41.20</td>
<td>Other idiopathic scoliosis, site unspecified</td>
</tr>
<tr>
<td>M41.22</td>
<td>Other idiopathic scoliosis, cervical region</td>
</tr>
<tr>
<td>M41.23</td>
<td>Other idiopathic scoliosis, cervicothoracic region</td>
</tr>
<tr>
<td>M41.24</td>
<td>Other idiopathic scoliosis, thoracic region</td>
</tr>
<tr>
<td>M41.25</td>
<td>Other idiopathic scoliosis, thoracolumbar region</td>
</tr>
<tr>
<td>M41.26</td>
<td>Other idiopathic scoliosis, lumbar region</td>
</tr>
</tbody>
</table>
Is code **M41.124 - Adolescent idiopathic scoliosis, thoracolumbar region** appropriate for congenital scoliosis?

No, excludes1, should be **Q67.5 Congenital deformity of the spine**
Excludes 1 – Congenital Example

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M40.40</td>
<td>Postural lordosis, site unspecified</td>
</tr>
<tr>
<td>M40.45</td>
<td>Postural lordosis, thoracolumbar region</td>
</tr>
<tr>
<td>M40.46</td>
<td>Postural lordosis, lumbar region</td>
</tr>
<tr>
<td>M40.47</td>
<td>Postural lordosis, lumbosacral region</td>
</tr>
<tr>
<td>M40.5</td>
<td>Lordosis, unspecified</td>
</tr>
<tr>
<td>M40.50</td>
<td>Lordosis, unspecified, site unspecified</td>
</tr>
<tr>
<td>M40.55</td>
<td>Lordosis, unspecified, thoracolumbar region</td>
</tr>
<tr>
<td>M40.56</td>
<td>Lordosis, unspecified, lumbar region</td>
</tr>
<tr>
<td>M40.57</td>
<td>Lordosis, unspecified, lumbosacral region</td>
</tr>
</tbody>
</table>

**Scoliosis**

Includes:
- Kyphoscoliosis

Excludes 1:
- Congenital scoliosis NOS (Q67.5)
- Congenital scoliosis due to bony malformation (Q76.3)
- Postural congenital scoliosis (Q67.5)
- Kyphoscoliotic heart disease (I27.1)
- Procedural scoliosis (M96.-)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M41.12</td>
<td>Adolescent scoliosis</td>
</tr>
<tr>
<td>M41.122</td>
<td>Adolescent idiopathic scoliosis, cervical region</td>
</tr>
<tr>
<td>M41.123</td>
<td>Adolescent idiopathic scoliosis, cervicothoracic region</td>
</tr>
<tr>
<td>M41.124</td>
<td>Adolescent idiopathic scoliosis, thoracic region</td>
</tr>
<tr>
<td>M41.125</td>
<td>Adolescent idiopathic scoliosis, thoracolumbar region</td>
</tr>
<tr>
<td>M41.126</td>
<td>Adolescent idiopathic scoliosis, lumbar region</td>
</tr>
<tr>
<td>M41.127</td>
<td>Adolescent idiopathic scoliosis, lumbosacral region</td>
</tr>
<tr>
<td>M41.129</td>
<td>Adolescent idiopathic scoliosis, site unspecified</td>
</tr>
</tbody>
</table>

**Other idiopathic scoliosis**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M41.20</td>
<td>Other idiopathic scoliosis, site unspecified</td>
</tr>
<tr>
<td>M41.22</td>
<td>Other idiopathic scoliosis, cervical region</td>
</tr>
<tr>
<td>M41.23</td>
<td>Other idiopathic scoliosis, cervicothoracic region</td>
</tr>
<tr>
<td>M41.24</td>
<td>Other idiopathic scoliosis, thoracic region</td>
</tr>
<tr>
<td>M41.25</td>
<td>Other idiopathic scoliosis, thoracolumbar region</td>
</tr>
<tr>
<td>M41.26</td>
<td>Other idiopathic scoliosis, lumbar region</td>
</tr>
</tbody>
</table>
Suzie Derkins reports to the office today after falling at home out of her bed. She appears to suffer from thoracolumbar radiculopathy as a result. She states that she was previously diagnosed with neuralgia.

The coder selects M54.15 and M79.2. This is wrong. Why?

Excludes1
**Excludes 1**

Brachial neuritis or radiculitis NOS
Lumbar neuritis or radiculitis NOS
Lumbosacral neuritis or radiculitis NOS
Thoracic neuritis or radiculitis NOS
Radiculitis NOS

Excludes 1:

- neuralgia and neuritis NOS (M79.2)
- radiculopathy with cervical disc disorder (M50.1)
- radiculopathy with lumbar and other intervertebral disc disorder (M51.1-)
- radiculopathy with spondylosis (M47.2-)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M53.3</td>
<td>Sacrococcygeal disorders, not elsewhere classified</td>
</tr>
<tr>
<td>M53.8</td>
<td>Other specified dorsopathies</td>
</tr>
<tr>
<td>M53.80</td>
<td>Other specified dorsopathies, site unspecified</td>
</tr>
<tr>
<td>M53.81</td>
<td>Other specified dorsopathies, occipito-atlanto-axial region</td>
</tr>
<tr>
<td>M53.82</td>
<td>Other specified dorsopathies, cervical region</td>
</tr>
<tr>
<td>M53.83</td>
<td>Other specified dorsopathies, cervicothoracic region</td>
</tr>
<tr>
<td>M53.84</td>
<td>Other specified dorsopathies, thoracic region</td>
</tr>
<tr>
<td>M53.85</td>
<td>Other specified dorsopathies, thoracolumbar region</td>
</tr>
<tr>
<td>M53.86</td>
<td>Other specified dorsopathies, lumbar region</td>
</tr>
<tr>
<td>M53.87</td>
<td>Other specified dorsopathies, lumbosacral region</td>
</tr>
<tr>
<td>M53.88</td>
<td>Other specified dorsopathies, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td>M53</td>
<td>Other and unspecified dorsopathies, not elsewhere classified</td>
</tr>
<tr>
<td>M53.9</td>
<td>Dorsopathy, unspecified</td>
</tr>
<tr>
<td>M54</td>
<td>DORSALGIA</td>
</tr>
<tr>
<td>M54</td>
<td>Dorsalgia</td>
</tr>
</tbody>
</table>
Suzie Derkins reports to the office today after falling at home out of her bed. She appears to suffer from thoracolumbar radiculopathy as a result. She states that she was previously diagnosed with neuralgia.

Use the index to find the appropriate External Cause codes for this scenario. (hint: one describes the place of the accident and the other explains the cause of the injury)

W06.xxxA Fall from bed (fall from → bed)

Y92.013 Bedroom of single family house (look up “place” in the index, then browse Y92)
External Cause Lookup

**Encounter for general**
- adult medical examination, Z00.0
- examination without complaint, suspected or reported diagnosis, Z00
- psychiatric examination, requested by authority, Z04.6
- issue of medical certificate, Z02.7
- newborn, infant and child health examinations, Z00.1
- other administrative examinations, Z02.8
- other aftercare, Z51
- other general examination, Z00.8
- other orthopedic aftercare, Z47.8
- other specified aftercare, Z51.8

**Encounter for screening for**
- cardiovascular disorders, Z13.6
- certain developmental disorders in childhood, Z13.4
- dental disorders, Z13.84
- disorder due to exposure to contaminants, Z13.88
- eye and ear disorders, Z13.5
- genetic and chromosomal anomalies, Z13.7

**Fall**
- Face and neck, Other congenital malformations of, Q18
- Facial nerve disorders, G51
- Factors Influencing health status and contact with health services, Z00-Z99
- Fall due to
  - bumping against object, W18.0
  - ice and snow, W00
  - Fall from
    - bed, W06
    - chair, W07
    - cliff, W15
    - non-moving wheelchair, nonmotorized scooter and motorized mobility scooter, W05
    - or off toilet, W18.1
    - other furniture, W08
    - tree, W14
    - out of or through building or structure, W13
- Fall in (into)
  - bucket of water, W16.22
  - filled bathtub, W16.21
Place of Occurrence Lookup

findings, Z71.2
encountering health services to consult on behalf of another person, Z71.0
on outside of car injured in collision with car, pick-up truck or van in nontraffic accident, V43.2

Place of occurrence of the external cause, Y92
farm, Y92.7
industrial and construction area, Y92.6

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| Y92.01 | Single-family non-institutional (private) house as the place of occurrence of the external cause
|       | Farmhouse as the place of occurrence of the external cause                   |
|       | Excludes1:                                                                  |
|       | barn (Y92.71)                                                                |
|       | chicken coop or hen house (Y92.72)                                           |
|       | farm field (Y92.73)                                                          |
|       | orchard (Y92.74)                                                             |
|       | single family mobile home or trailer (Y92.02)                                |
|       | slaughter house (Y92.86)                                                     |
| Y92.010 | Kitchen of single-family (private) house as the place of occurrence of the external cause |
| Y92.011 | Dining room of single-family (private) house as the place of occurrence of the external cause |
| Y92.012 | Bathroom of single-family (private) house as the place of occurrence of the external cause |
| Y92.013 | Bedroom of single-family (private) house as the place of occurrence of the external cause |
| Y92.025 | Garage of mobile home as the place of occurrence of the external cause        |
| Y92.026 | Swimming-pool of mobile home as the place of occurrence of the external cause |
| Y92.027 | Garden or yard of mobile home as the place of occurrence of the external cause |
| Y92.028 | Other place in mobile home as the place of occurrence of the external cause   |
| Y92.029 | Unspecified place in mobile home as the place of occurrence of the external cause |
| Y92.030 | Kitchen in apartment as the place of occurrence of the external cause         |
| Y92.031 | Bathroom in apartment as the place of occurrence of the external cause        |
| Y92.032 | Apartment as the place of occurrence of the external cause                   |
| Y92.033 | Condominium as the place of occurrence of the external cause                 |
| Y92.034 | Co-op apartment as the place of occurrence of the external cause             |
| Y92.035 | Other place in apartment as the place of occurrence of the external cause     |

20. External Causes of Morbidity (V00–Y99)
Why can’t you use M75.111 for a traumatic rotator cuff tear?

Excludes1 under M75.1 for S46.01
Excludes 1:

- tear of rotator cuff, traumatic (S46.01-)

M75.1 Rotator cuff tear or rupture, not specified as traumatic
  Rotator cuff syndrome
  Supraspinatus tear or rupture, not specified as traumatic

M75.10 Unspecified rotator cuff tear or rupture, not specified as traumatic
  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

M75.11 Incomplete rotator cuff tear or rupture not specified as atraumatic
  M75.110 Incomplete rotator cuff tear or rupture of unspecified shoulder, not specified as atraumatic
  M75.111 Incomplete rotator cuff tear or rupture of right shoulder, not specified as atraumatic
  M75.112 Incomplete rotator cuff tear or rupture of left shoulder, not specified as atraumatic

M75.5 Bursitis of shoulder
  M75.50 Bursitis of unspecified shoulder
  M75.51 Bursitis of right shoulder
  M75.52 Bursitis of left shoulder

M75.8 Other shoulder lesions
  M75.80 Other shoulder lesions, unspecified shoulder
  M75.81 Other shoulder lesions, right shoulder
  M75.82 Other shoulder lesions, left shoulder

M75.9 Shoulder lesion, unspecified
  M75.90 Shoulder lesion, unspecified, unspecified shoulder
  M75.91 Shoulder lesion, unspecified, right shoulder
  M75.92 Shoulder lesion, unspecified, left shoulder

M76 ENTHESOPATHIES, LOWER LIMB, EXCLUDING FOOT
  Excludes2:
    bursitis due to use, overuse and pressure (M70.-)
    enthesopathies of ankle and foot (M77.5-)

M76.0 Gluteal tendinitis
  M76.00 Gluteal tendinitis, unspecified hip
A patient comes in on October 20, 2015 complaining of heel and foot pain, especially in the morning. You diagnose the patient with Plantar Fasciitis, What are the steps to code for this diagnosis?
Step 1: Alphabetic Index

- Institutional (nonprivate) residence, Y92.1
- Non-institutional (private) residence, Y92.0
- School, other institution and public administrative area, hospital, Y92.2
- Sports and athletics area, Y92.3
- Street, highway and other paved roadways, Y92.4
- Trade and service area, Y92.5
- Wilderness, recreation area, Y92.8

- **Plantar fascial fibromatosis, M72.2**

- Plantar nerve, lesion of, G57.6
- Plexus disorders, G54
- Plica syndrome, M67.5
- Pneumococcal arthritis and polyarthritis, M00.1
- Poliomyelitis, sequelae of, B91
- Polyarthritis, M00.0
- Polyarthropathies, inflammatory, M05-M14
- Polychondritis, Relapsing, M94.1
- Polynuromathy and other disorders of the

- Prostate, enlarged, N40
- Pseudarthrosis after fusion or arthrodesis, M96.0
- Pseudocoxalgia, M91.3
- Pseudohypoparathyroidism, E20.1
- Pseudosarcomatous fibromatosis, M72.4

- Q
  - Quadriplegia, G82.5

- R
  - Radial
    - nerve, lesion of, G56.3
    - styloid tenosynovitis [de Quervain], M65.4
  - Radiculopathy, M54.1
  - Recreation area as the place of occurrence of the external cause, Y92.83
  - Reduction defects of
    - lower limb O72.
Step 2: Tabular Listing

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M71.5</td>
<td>Other bursitis, not elsewhere classified, unspecified site</td>
</tr>
<tr>
<td>M71.58</td>
<td>Other bursitis, not elsewhere classified, other site</td>
</tr>
<tr>
<td>M71.60</td>
<td>Other specified bursopathies, unspecified site</td>
</tr>
<tr>
<td>M71.8</td>
<td>Other specified bursopathies</td>
</tr>
<tr>
<td>M71.81</td>
<td>Other specified bursopathies, shoulder</td>
</tr>
<tr>
<td>M71.82</td>
<td>Other specified bursopathies, elbow</td>
</tr>
<tr>
<td>M71.83</td>
<td>Other specified bursopathies, wrist</td>
</tr>
<tr>
<td>M71.84</td>
<td>Other specified bursopathies, left shoulder</td>
</tr>
<tr>
<td>M71.85</td>
<td>Other specified bursopathies, right shoulder</td>
</tr>
<tr>
<td>M71.86</td>
<td>Other specified bursopathies, unspecified shoulder</td>
</tr>
<tr>
<td>M71.87</td>
<td>Other specified bursopathies, unspecified ankle and foot</td>
</tr>
<tr>
<td>M71.88</td>
<td>Other specified bursopathies, other site</td>
</tr>
<tr>
<td>M71.89</td>
<td>Other specified bursopathies, multiple sites</td>
</tr>
<tr>
<td>M71.9</td>
<td>Bursopathy, unspecified</td>
</tr>
<tr>
<td>M71.91</td>
<td>Bursitis NOS</td>
</tr>
<tr>
<td>M72.0</td>
<td>FIBROBLASTIC DISORDERS</td>
</tr>
<tr>
<td>M72.1</td>
<td>Knuckle pads</td>
</tr>
<tr>
<td>M72.2</td>
<td>Plantar fascial fibromatosis</td>
</tr>
<tr>
<td>M72.3</td>
<td>Plantar fascilitis</td>
</tr>
<tr>
<td>M72.4</td>
<td>Pseudosarcomatous fibromatosis</td>
</tr>
<tr>
<td>M72.5</td>
<td>Nodular fasciitis</td>
</tr>
<tr>
<td>M72.6</td>
<td>Necrotizing fasciitis</td>
</tr>
<tr>
<td>M72.7</td>
<td>Use additional code (B95., B96.) to identify causative organism</td>
</tr>
<tr>
<td>M72.8</td>
<td>Other fibroblastic disorders</td>
</tr>
<tr>
<td>M72.9</td>
<td>Abscess of fascia</td>
</tr>
</tbody>
</table>

No Excludes 1
Make sure to
Consider
Excludes 2
How do I implement ICD-10 in my practice?
How do I implement ICD-10 in my practice?

Questions for your software vendors:

• Do I need to pay for an upgrade?
• Will the software have a built in crosswalk? If so, is it based only on GEMs?
• Will you provide any training or assistance?
• Will the software be able to report both ICD-9 and ICD-10 codes if necessary?
• When will you be ready to test your program?

What Areas of My Practice Will be Affected?

- Front Desk
  - New HIPAA Privacy Policies
  - System Updates, training, etc.

- Management
  - New Policies and Procedures
  - Vendor and Payer Contracts – watch out for this one.
  - Budget (software, training, forms, etc.)
  - Training Plan
What Areas of My Practice Will be Affected?

- Providers
  - Documentation – much more specificity
  - Code specific training - 14,000 → 68,000…

- Clinical Areas
  - Patient Coverage Policies will most likely change
  - Super bills – may need to be eliminated
  - Changes to ABN’s – Intermediaries will most likely revise policies for LCD’s, etc.. New ABN’s may be required and explained to patients.
What Areas of My Practice Will be Affected?

- Billing
  - New Code Set
  - Significant training
  - New reimbursement policies means new follow up, potential for increased denials, etc.
- Other?
How do I implement ICD-10 in my practice?

According to CMS, 1 in 5 physician practices will see Medicare denials double within 6 months because they weren't prepared for ICD-10 by Oct. 1, 2014.
How do I implement ICD-10 in my practice?

1. Talk to your current practice management system vendor.
2. Talk to your clearinghouses or billing service.
3. Identify changes to data reporting requirements.
4. Identify the changes that you need to make in your practice to convert to the ICD-10 code set. For example, your diagnosis coding tools, “super bills”, public health reporting tools, etc.
5. Identify staff training needs and begin the process.
6. Budget for implementation costs, including expenses for system changes, resource materials, consultants, and training.
How do I implement ICD-10 in my practice?

7. Run a report to see what Diagnoses you use most frequently
8. Review some sample charts with those codes used
9. Could you code a diagnosis now using ICD-10? Does your documentation include all the necessary detail that will be required in ICD-10? E.g. onset, contributory factors, and other detail necessary?
10. Gather the data from this test and start to educate the practice on changes in documentation needed
How do I implement ICD-10 in my practice?

**Medicare:** free training

**ChiroCode.com:** free email alerts and webinars, more training, memberships, and chart audits, coding tools

**FindACode.com:** Crosswalks and other advanced tools

**ICD10Monitor.com:** free articles

**AAPC.com** and **AHIMA.org**
Thank You

For More Information Contact

David Klein

dave@paydc.com

215-957-1035