

ICD-10-CM and PODIATRY



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Coding Guidelines

Many of the guidelines under ICD-9-CM won't change under ICD-10-CM. You will see new guidelines because ICD-10 will offer new codes never seen before. As an example of guidelines that will look familiar to you:

ICD-9 Guideline for Symptoms:

Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the physician. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 -799.9) contain many, but not all codes for symptoms.

7. Conditions that are an integral part of a disease process

Signs and symptoms that are integral to the disease process should not be assigned as additional codes.

8. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

ICD-10 Guideline for Symptoms:

Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

5. Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

6. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

As you can see, both guidelines are virtually identical, so the change to ICD-10 wont be a shock to a trained coder.

Coding Guidelines for Podiatry

The following are some ICD-10 coding guidelines that may impact Podiatry providers. Please note that these are not ALL of the ICD-10 guidelines, just a sample, and, again, these look identical to ICD-9 guidelines. These guidelines are published by the World Health Organization:

Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

Multiple coding for a single condition

In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. "Use additional code" notes are found in the Tabular at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair, "use additional code" indicates that a secondary code should be added.

"Code first" notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a "code first" note and an underlying condition is present, the underlying condition should be sequenced first.

"Code, if applicable, any causal condition first", notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

Multiple codes may be needed for late effects, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

a. Site and laterality

Most of the codes have site and laterality designations. The site represents either the bone, joint or the muscle involved. For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis, there is a "multiple sites" code available. For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved.

Bone versus joint

For certain conditions, the bone may be affected at the upper or lower end, (e.g., avascular necrosis of bone, M87, Osteoporosis, M80, M81). Though the portion of the bone affected may be at the joint, the site designation will be the bone, not the joint.

Acute traumatic versus chronic or recurrent musculoskeletal conditions

Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions. Bone, joint or muscle conditions that are the result of a healed injury are usually found in chapter 13. Recurrent bone, joint or muscle conditions are also usually found in chapter 13. Any current, acute injury should be coded to the appropriate injury code from chapter 19. Chronic or recurrent conditions should generally be coded with a code from chapter 13. If it is difficult to determine from the documentation in the record which code is best to describe a condition, query the provider.

Osteoporosis

Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected. Therefore, site is not a component of the codes under category M81, Osteoporosis without current pathological fracture. The site codes under category M80, Osteoporosis with current pathological fracture, identify the site of the fracture, not the osteoporosis.

Osteoporosis without pathological fracture

Category M81, Osteoporosis without current pathological fracture, is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past. For patients with a history of osteoporosis fractures, status code Z87.31, Personal history of osteoporosis fracture, should follow the code from M81.

Late Effects (Sequela)

A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury. Coding of late effects generally requires two codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second.

An exception to the above guidelines are those instances where the code for late effect is followed by a manifestation code identified in the Tabular List and title, or the late effect code has been expanded (at the fourth, fifth or sixth character levels) to include the manifestation(s). The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect.

Impending or Threatened Condition

Code any condition described at the time of discharge as "impending" or "threatened" as follows:

If it did occur, code as confirmed diagnosis.

If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for "impending" or "threatened" and also reference main term entries for "Impending" and for "Threatened."

If the subterms are listed, assign the given code.

If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

Reporting Same Diagnosis Code More than Once

Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions **when there are no**

distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code.

Laterality

For bilateral sites, the final character of the codes in the ICD-10-CM indicates laterality. An unspecified side code is also provided should the side not be identified in the medical record. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.

Coding of Injuries

When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Multiple injury codes are provided in ICD-10-CM, but should not be assigned unless information for a more specific code is not available. These **traumatic injury** codes (S00-T14.9) are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.

The code for the most serious injury, as determined by the provider and the focus of treatment, is sequenced first.

Primary injury with damage to nerves/blood vessels

When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) for injuries to nerves and spinal cord (such as category S04), and/or injury to blood vessels (such as category S15). When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

External Causes of Morbidity (V01- Y99)

Introduction: These guidelines are provided for the reporting of external causes of morbidity codes in order that there will be standardization in the process. These codes are secondary codes for use in any health care setting.

External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred the activity of the patient at the time of the event, **and the person's status (e.g., civilian, military).**

GENERAL EXTERNAL CAUSE CODING GUIDELINES

Used with any code in the range of A00.0-T88.9, Z00-Z99

An external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99, classification that is a health condition due to an external cause. Though they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack that occurs during strenuous physical activity.

External cause code used for length of treatment

Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated.

Use the full range of external cause codes

Use the full range of external cause codes to completely describe the cause, the intent, the place of occurrence, **and if applicable**, the activity of the patient at the time of the event, **and the patient's status**, for all injuries, and other health conditions due to an external cause.

Assign as many external cause codes as necessary

Assign as many external cause codes as necessary to fully explain each cause. If only one external code can be recorded, assign the code most related to the principal diagnosis.

The selection of the appropriate external cause code

The selection of the appropriate external cause code is guided by the Index to External Causes, which is located after the Alphabetical Index to diseases and by Inclusion and Exclusion notes in the Tabular List.

External cause code can never be a principal diagnosis

An external cause code can never be a principal (first listed) diagnosis.

Combination external cause codes

Certain of the external cause codes are combination codes that identify sequential events that result in an injury, such as a fall which results in striking against an object. The injury may be due to either event or both. The combination external cause code used should correspond to the sequence of events regardless of which caused the most serious injury.

Multiple External Cause Coding Guidelines

More than one external cause code is required to fully describe the external cause of an illness, injury or poisoning. The assignment of external cause codes should be sequenced in the following priority:

If two or more events cause separate injuries, an external cause code should be assigned for each cause.

Unknown or Undetermined Intent Guideline

If the intent (accident, self-harm, assault) of the cause of an injury or other condition is unknown or unspecified, code the intent as accidental intent. All transport accident categories assume accidental intent.

Late Effects of External Cause Guidelines

Late effect external cause codes

Late effects are reported using the external cause code with the 7th character extension "S" for sequela. These codes should be used with any report of a late effect or sequela resulting from a previous injury.

Late effect external cause code with a related current injury

A late effect external cause code should never be used with a related current nature of injury code.

Use of late effect external cause codes for subsequent visits

Use a late effect external cause code for subsequent visits when a late effect of the initial injury is being treated. Do not use a late effect external cause code for subsequent visits for follow-up care (e.g., to assess healing, to receive rehabilitative therapy) of the injury or poisoning when no late effect of the injury has been documented.

External cause status

A code from category Y99, External cause status, should be assigned whenever any other external cause code is assigned for an encounter, including an Activity code, except for the events noted below. Assign a code from category Y99, External cause status, to indicate the work status of the person at the time the event occurred. The status code indicates whether the event occurred during military activity, whether a non-military person was at work, whether an individual including a student or

volunteer was involved in a non-work activity at the time of the causal event. A code from Y99, External cause status, should be assigned, when applicable, with other external cause codes, such as transport accidents and falls. The external cause status codes are not applicable to poisonings, adverse effects, misadventures or late effects.

Do not assign a code from category Y99 if no other external cause codes (cause, activity) are applicable for the encounter.

Do not assign code Y99.9, Unspecified external cause status, if the status is not stated.

History (of)

There are two types of history Z codes, personal and family. Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Personal history codes may be used in conjunction with follow-up codes and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are also acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

The history Z code categories are:

- Z80 Family history of primary malignant neoplasm
- Z81 Family history of mental and behavioral disorders
- Z82 Family history of certain disabilities and chronic diseases (leading to disablement)
- Z83 Family history of other specific disorders
- Z84 Family history of other conditions
- Z85 Personal history of malignant neoplasm
- Z86 Personal history of certain other diseases
- Z87 Personal history of other diseases and conditions
- Z91.4- Personal history of psychological trauma, not elsewhere classified

Z91.5 Personal history of self-harm

Z91.8- Other specified personal risk factors, not elsewhere classified

Z92 Personal history of medical treatment

Except: Z92.0, Personal history of contraception

Except: Z92.82, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to a current facility

Screening

Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease (e.g., screening mammogram).

The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.

A screening code may be a first listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination.

Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis.

The Z code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed.

The screening Z codes/categories:

Z11 Encounter for screening for infectious and parasitic diseases

Z12 Encounter for screening for malignant neoplasms

Z13 Encounter for screening for other diseases and disorders

Except: Z13.9, Encounter for screening, unspecified

Z36 Encounter for antenatal screening for mother

Aftercare

Aftercare visit codes cover situations when the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare Z code should not be used if treatment is directed at a current, acute disease. The diagnosis code is to be used in these cases.

Exceptions to this rule are codes Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy. These codes are to be first listed, followed by the diagnosis code when a patient's encounter is solely to receive radiation therapy, chemotherapy, or immunotherapy for the treatment of a neoplasm. If the reason for the encounter is more than one type of antineoplastic therapy, code Z51.0 and a code from subcategory Z51.1 may be assigned together, in which case one of these codes would be reported as a secondary diagnosis.

The aftercare Z codes should also not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with the 7th character "D" (subsequent encounter).

The aftercare codes are generally first listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable. An example of this would be the closure of a colostomy during an encounter for treatment of another condition.

Aftercare codes should be used in conjunction with other aftercare codes or diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. Should a patient receive multiple types of antineoplastic therapy during the same encounter, code Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy, may be used together on a record. The sequencing of multiple aftercare codes **depends on the circumstances of the encounter.**

Certain aftercare Z code categories need a secondary diagnosis code to describe the resolving condition or sequelae. For others, the condition is **included** in the code title.

Additional Z code aftercare category terms include fitting and adjustment, and attention to artificial openings.

Status Z codes may be used with aftercare Z codes to indicate the nature of the aftercare. For example code Z95.1, Presence of aortocoronary bypass graft, may be used with code Z48.812, Encounter for surgical aftercare following surgery on the circulatory system, to indicate the surgery for which the aftercare is being performed. A status code should not be used when the aftercare code indicates the type of status, such as using Z43.0, Encounter for attention to tracheostomy, with Z93.0, Tracheostomy status.

The aftercare Z category/codes:

Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury

Z43 Encounter for attention to artificial openings

Z44 Encounter for fitting and adjustment of external prosthetic device

Z45 Encounter for adjustment and management of implanted device

Z46 Encounter for fitting and adjustment of other devices

Z47 Orthopedic aftercare

Z48 Encounter for other postprocedural aftercare

Z49 Encounter for care involving renal dialysis

Z51 Encounter for other aftercare

Follow-up

The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes, or injury codes with 7th character "D," that explain ongoing care of a healing condition or its sequelae. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code.

A follow-up code may be used to explain **multiple** visits. Should a condition be found to have recurred on the follow-up visit, then the code for the condition should be assigned as an additional diagnosis.

The follow-up Z code categories:

Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm

Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

Z39 Encounter for maternal postpartum care and examination

Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.

When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

Two or more diagnoses that equally meet the definition for principal diagnosis

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

Two or more comparative or contrasting conditions.

In those rare instances when two or more contrasting or comparative diagnoses are documented as "either/or" (or similar terminology), they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

A symptom(s) followed by contrasting/comparative diagnoses

When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional diagnoses.

Original treatment plan not carried out

Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

Previous conditions

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Abnormal findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

Please note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.

Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out" or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

Selection of first-listed condition

In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.

In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index.

Accurate reporting of ICD-10-CM diagnosis codes

For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these.

Encounters for circumstances other than a disease or injury

ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00-99) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

Level of Detail in Coding

ICD-10-CM codes with 3, 4, or 5 digits

ICD-10-CM is composed of codes with either 3, 4, 5, 6 or 7 digits. Codes with three digits are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth fifth digits, sixth or seventh digits which provide greater specificity.

Use of full number of digits required for a code

A three-digit code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character extension, if applicable.

ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

Uncertain diagnosis

Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

Chronic diseases

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Patients receiving diagnostic services only

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

Patients receiving therapeutic services only

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

Podiatry Diagnosis Codes

The following are some of the most used codes in some Podiatric practices. Please understand that this guide does NOT contain all codes used. This guide does not take the place of coding or published coding manuals. This is NOT a coding cheat sheet. This guide is NOT to be used to assign a diagnostic code to a service. *WE DO NOT AND WE NEVER CODE ASSIGNING A CODE TO A SERVICE!!!* This guide is to show you what the codes you use will look like when ICD-10 takes place on October 1, 2015. I am also trying to show you that ICD-10 is not as scary as some may wish you to believe

NUMERICAL ORDER BY ICD-9-CM

ICD-9-CM

078.12 Plantar wart

ICD-10-CM

B07.0 Plantar wart

ICD-9-CM

111.01 Onychomycosis

ICD-10-CM

B35.1 Tinea unguium

ICD-9-CM

682.7 – Cellulitis of foot

ICD-10-CM

L03.119 - Cellulitis of unspecified part of limb

L03.129 Acute lymphangitis of unspecified part of limb

ICD-9-CM

700 Corns and callosities

ICD-10-CM

L84 Corns and callosities

ICD-9-CM

703.0 Ingrowing Nail

ICD-10-CM

L60.0 Ingrowing nail

ICD-9-CM

726.71 Achilles bursitis or tendinitis

ICD-10-CM

M76.60 Achilles tendinitis, unspecified leg

M76.61 Achilles tendinitis, right leg

M76.62 Achilles tendinitis, left leg

ICD-9-CM

726.73 Calcaneal Spur

ICD-10-CM

M77.30 Calcaneal spur, unspecified foot

M77.31 Calcaneal spur, right foot

M77.32 Calcaneal spur, left foot

ICD-9-CM

727.1 Bunion

ICD-10-CM

M20.10 Hallux valgus (acquired), unspecified foot

M20.11 Hallux valgus (acquired), right foot

M20.12 Hallux valgus (acquired), left foot

ICD-9-CM

733.00 Osteoporosis, unspecified

ICD-10-CM

M81.0 Age-related osteoporosis without current pathological fracture

M81.6 Localized osteoporosis [Lequesne]

M81.8 Other osteoporosis without current pathological fracture

ICD-9-CM

734 Flat Foot

ICD-10-CM

M21.40 - Flat foot [pes planus] (acquired), unspecified foot

M21.41 - Flat foot [pes planus] (acquired), right foot

M21.42 - Flat foot [pes planus] (acquired), left foot

ICD-9-CM

735.5 Claw Toe

ICD-10-CM

M20.5X9 Other deformities of toe(s) (acquired), unspecified foot

M20.5X1 Other deformities of toe(s) (acquired), right foot

M20.5X2 Other deformities of toe(s) (acquired), left foot

ICD-9-CM

754.61 Congenital Flat Foot

ICD-10-CM

Q66.50 Congenital pes planus (pes planus congenital flat foot congenital rigid flat)

Q66.51 Congenital pes planus, right foot

Q66.52 Congenital pes planus, left foot

ICD-9-CM

782.3 – Edema

ICD-10-CM

R60.0 – Localized Edema

R60.1 – Generalized Edema

R60.9 – Edema, Unspecified

ICD-9-CM

895.0 Amputation, Traumatic of toe(s) (complete) (partial) without mention of complication

ICD-10-CM

S98.119A Complete traumatic amputation of unspecified great toe, initial encounter

S98.129A Partial traumatic amputation of unspecified great toe, initial encounter

S98.139A Complete traumatic amputation of one unspecified lesser toe, initial encounter

S98.149A Partial traumatic amputation of one unspecified lesser toe, initial encounter

S98.219A Complete traumatic amputation of two or more unspecified lesser toes, initial encounter

S98.229A Partial traumatic amputation of two or more unspecified lesser toes, initial encounter

The Coding Process

The process for coding ICD-10 is no different than that of ICD-9, but documentation will be the success or failure of ICD-10. Improper or lack of documentation will only delay claims processing and will decrease practice revenue. The coder reads the medical record. The coder reads that the doctor documented "Chest pain". The coder opens the ICD-10 manual, goes to the Index (words) and looks up the condition, which in this case is Pain.

Pain(s) (see also Painful) R52

- - chest (central) R07.9
- - - anterior wall R07.89
- - - atypical R07.89
- - - ischemic I20.9
- - - musculoskeletal R07.89
- - - non-cardiac R07.89
- - - on breathing R07.1
- - - pleurodynia R07.81
- - - precordial R07.2
- - - wall (anterior) R07.89

As you can see from the above ICD-10 index, you have chest pain listed as R07.9. Next you want to go to the tabular section to make sure that R07.9 is the correct code and to see if there are any coding conventions. Coding conventions provide us with additional information we need to ensure we have the correct code. The ICD-10 codes are identified in bold print. The coding conventions are not bold. If you are familiar with the ICD-9 coding conventions, they look familiar to you in ICD-10. The red printing identifies the correct code and it's description. That is what I did for easy identification.

The tabular for R07 is below.

- **R07 Pain in throat and chest**
- Excludes.:dysphagia (R13) epidemic myalgia (B33.0) pain in:breast (N64.4)
- neck (M54.2)
- sore throat (acute) NOS (J02.9)
- **R07.0 Pain in throat**
- **R07.1 Chest pain on breathing**
- Incl.:Painful respiration
- **R07.2 Precordial pain**
- **R07.3 Other chest pain**
- Incl.:Anterior chest-wall pain NOS
- **R07.9 Chest pain, unspecified**

If you look at the above tabular section, you can see coding conventions identical to those from ICD-9-CM. You can see NOS which means Not Otherwise Specified, Incl which means Includes and excludes which means these medical conditions are not included in this code. Code R07.4 has no coding conventions or additional information, so, based on the medical record documentation of chest pain, we can select R07.4. Again, if you can code ICD-9, you can code ICD-10. If you don't have the training in the process of coding, you wont be able to code under ICD-10.

CODING CHAPTERS

Under ICD-9-CM, you have the following:

- Chapter 1: Infectious and Parasitic Diseases (001-139)
- Chapter 2: Neoplasms (140-239)

Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
Chapter 4: Diseases of Blood and Blood Forming Organs (280-289)
Chapter 5: Mental Disorders (290-319)
Chapter 6: Diseases of Nervous System and Sense Organs (320-389)
Chapter 7: Diseases of Circulatory System (390-459)
Chapter 8: Diseases of Respiratory System (460-519)
Chapter 9: Diseases of Digestive System (520-57)
Chapter 10: Diseases of Genitourinary System (580-629)
Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630-677)
Chapter 12: Diseases Skin and Subcutaneous Tissue (680-709)
Chapter 13: Diseases of Musculoskeletal and Connective Tissue (710-739)
Chapter 14: Congenital Anomalies (740-759)
Chapter 15: Newborn (Perinatal) Guidelines (760-779)
Chapter 16: Signs, Symptoms and Ill-Defined Conditions (780-799)
Chapter 17: Injury and Poisoning (800-999)
Chapter 18: Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V84) and Supplemental Classification of External Causes of Injury and Poisoning (E-codes, E800-E999)

Under ICD-10, you have the following:

Chapter 1: Certain infectious and parasitic diseases (A00-B99)
Chapter 2: Neoplasms (C00-D48)
Chapter 3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
Chapter 4: Endocrine, nutritional and metabolic diseases (E00-E90)
Chapter 5: Mental and behavioral disorders (F01-F99)
Chapter 6: Diseases of the nervous system (G00-G99)
Chapter 7: Diseases of the eye and adnexa (H00-H59)
Chapter 8: Diseases of the ear and mastoid process (H60-H95)
Chapter 9: Diseases of the circulatory system (I00-I99)
Chapter 10: Acute upper respiratory infections (J00-J06)
Chapter 11: Diseases of oral cavity and salivary glands (K00-K14)
Chapter 12: Diseases of the skin and subcutaneous tissue (L00-L99)
Chapter 13: Diseases of the musculoskeletal system and connective tissue (M00-M99)
Chapter 14: Diseases of the genitourinary system (N00-N99)
Chapter 15: Pregnancy, childbirth and the puerperium (O00-O99)

Chapter 16: Certain conditions originating in the perinatal period (P00-P96)

Chapter 17: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)

Chapter 18: Symptoms and signs involving the circulatory and respiratory systems (R00-R09)

Chapter 19: Injury, poisoning and certain other consequences of external causes (S00-T98)

Chapter 20: External causes of morbidity (V01-Y98)

Factors influencing health status and contact with health services (Z00-Z99)

E Codes will become V-Y Codes

V Codes will become Z Codes.

The Table of Drugs and Biologicals that were 900 series codes and E Codes are now T Codes.

There were 18 Chapters in ICD-9-CM and we have 20 chapters under ICD-10-CM.

The effective date for ICD-10 is October 1, 2015.

The key to the successful use and transition to ICD-10 is going to ensure our Providers are aware of their responsibility towards better documentation of the patient's medical condition(s).

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