

ICD-10-CM Specialty Code Set Training Emergency Department

2014

Module 1



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Clinical Examples Used in this Book

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are *actual*, *redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real world* quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.

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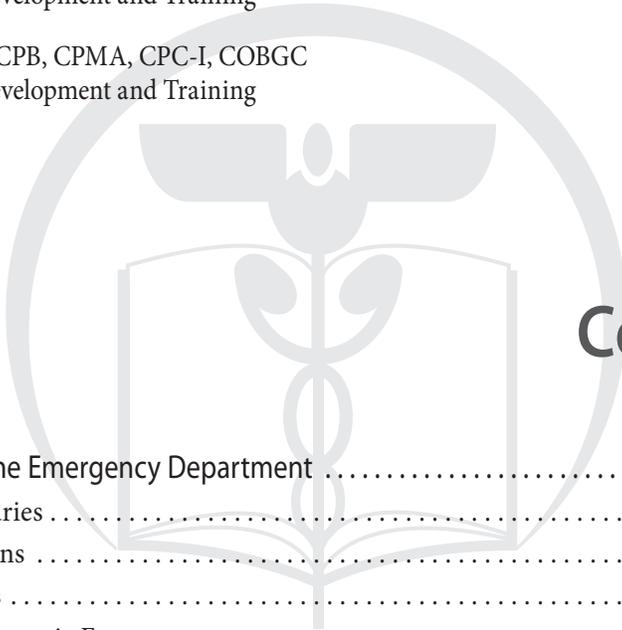
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Injury Coding in the Emergency Department

Emergency Department providers treat many injuries, including fractures. The codes for most of these injuries will be found in chapter 19, Injury, Poisoning, and Certain Other Consequences of External Causes. The code range for this chapter is S00 through T88. To gain a better understanding of how to code for these injuries we will take a look at the guidelines and codes associated with Chapter 19.

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. Code T07 *Unspecified multiple injuries* should not be assigned unless information for a more specific code is not available. Multiple injury codes are provided in ICD-10-CM, but should not be assigned unless information for a more specific code is not available. 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.

1. Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.
2. 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 and/or injury to blood vessels. When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

Code Extensions

Most categories in chapter 19 have seventh character extensions that are required for each applicable code. Most categories in this chapter have three extensions (with the exception of fractures): A, initial encounter; D, subsequent encounter; and S, sequela.

CODING TIP

Remember, the seventh character must always be the seventh character in the data field. If a code that requires a seventh character is not six characters in length, a placeholder X must be used to fill in the empty characters.

Extension A, initial encounter, is used while the patient is receiving active treatment for the injury. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

CODING TIP

Don't latch on to the word "initial" as this could hinder your appropriate selection, instead keep in mind the words "active treatment" as identified in the guidelines.

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

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

Extension S, sequela, is for use for complications or conditions that arise as a direct result of an injury, such as scar formation after a burn. The scars are sequelae of the burn. When using extension S, it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The S is added only to the injury code, not the sequela code. The S extension identifies the injury responsible for the sequela. The specific type of sequela (eg, scar) is sequenced first, followed by the injury code.

The guidelines also give directives on the use of the external cause codes with injuries. The external cause code (how the injury occurred) should be reported with the appropriate seventh character for each encounter for which the injury or condition is being treated. Codes from category Y92, Place of occurrence of external cause, are to be reported only once at the initial encounter for treatment.

Codes from category Y93, Activity code, are to be reported only once at the initial encounter for treatment. Codes from category Y99, External cause status, should be reported only once, at the initial encounter for treatment.

EXAMPLE

Jill presents to emergency department with complaints of a fall in her bathroom at her house. She slipped on a towel while getting out of the shower and twisted her ankle. Her left ankle is swollen and she cannot bear full weight on it. An X-ray indicates no fracture. She is diagnosed with a sprain of the left anterior talofibular ligament. Her ankle is wrapped, she is given crutches, and informed to take Motrin for pain.

S93.492A Sprain of other ligament of left ankle, initial encounter

W01.0XXA Fall on same level from slipping, tripping, and stumbling without subsequent striking against object, initial encounter

Y92.012 Bathroom of single-family (private) house as the place of occurrence of the external cause

Y93.E1 Activity, personal bathing and showering

EXAMPLE

Cathy returns to the ED for a recheck of her right forearm laceration. The dressing was removed and the wound was checked and is healing well.

S51.811D Laceration without foreign body of right forearm, subsequent encounter

EXAMPLE

Michael presents with complaints of scar contracture from his 2nd degree burn to the left knee.

L90.5 Scar conditions and fibrosis of skin

T24.222S Burn of second degree of left knee, sequela

Open Wounds

There are no chapter specific guidelines for open wounds at this time. However, coding for open wounds in ICD 10 will be different than in ICD-9-CM. In ICD 9 any injury that is considered an open wound is classified as an open wound. In ICD-10-CM, open wounds can be coded more distinctly. There are separate subcategories for lacerations, puncture wounds, open bites and unspecified open wounds. There is also another layer of specificity for some anatomical sites to further clarify the extent of the injury. For example, for a laceration of the abdominal wall, the code subcategories include “with penetration into the peritoneal cavity” and “without penetration into the peritoneal cavity.” Some laceration and puncture wound codes are divided into “with foreign body” and “without foreign body.” There are some things that are common to each type of injury, such as site and laterality.

Codes for open wounds are broken down by the following:

Type of wound—Laceration, Puncture, Open bite, Unspecified open wound

Site—Anatomic location on the body

- Laterality
- With or without foreign body
- Encounter (seventh character extender)—Initial, Subsequent, or Sequela

According to the National Institute of Health a laceration is a wound that is produced by the tearing of soft body tissue. This type of wound is often irregular and jagged. A laceration wound is often contaminated with bacteria and debris from whatever object caused the cut.

A puncture wound is usually caused by a sharp pointy object such as a nail, animal teeth, or a tack. This type of wound usually does not bleed excessively and can appear to close up. Puncture wounds are also prone to infection and should be treated appropriately.

EXAMPLE

A patient presents to the ED for a recheck of a puncture wound to her left foot sustained after stepping on a nail. On the initial visit, the nail was found to be imbedded in the wound and was removed.

S91.342D Puncture wound with foreign body, left foot, subsequent encounter

The form and size of gunshot wounds depend on the projectile type, its velocity at impact and the type of tissue affected by the projectile. Gunshot wounds are always contaminated. While low velocity projectiles usually cause minimal wounds, high velocity projectiles can cause large, devastating wounds. Gunshot wounds are often emergencies. Projectiles usually become encapsulated.

Main term entries in the index for open wounds can either be the type of wound (ie, puncture), or the term wound, open. Using either term will allow the user to find the correct type of wound and anatomical location by using the indented subterms. For example, if you look up puncture wound of the abdomen in the index using the main term Wound, open and then going to the subterms Abdomen, wall, puncture; an instructional note will guide the user to “see” Puncture, abdomen, wall.

EXAMPLE

Patient presents to emergency department after being involved in a bar brawl. He has a handgun wound to the right lower abdomen. The surgeon took the patient to the operating room to remove the bullet which was still lodged in the abdominal wall. No additional information was available from the patient regarding the injury.

S31.143A Puncture wound of abdominal wall with foreign body, right lower quadrant, initial encounter

X93.XXXA Assault by handgun discharge, initial encounter

CODING TIP

Remember coding guidelines that state that if the activity of the patient, the location of the patient or external cause status of the patient is not known you would not use it with the unspecified codes. Only code for the information documented in the medical record.

Coding of Traumatic Fractures

A wide range of fractures are managed in the emergency department. The codes for fractures have greatly expanded in ICD-10-CM due to the specificity of site, inclusion of laterality, nature of the fracture (transverse, oblique, comminuted, segmental, etc) and seventh character extender additions. To accurately assign fracture codes the documentation must also include:

- Type of fracture—open or closed, including the Gustilo classification for open fractures
- Stage of healing—routine or delayed
- Complications—nonunion or malunion

ICD-10-CM traumatic fractures are coded classified in Chapter 19, Injury, Poisoning and Certain Other Consequences of External Causes.

While the level of specificity and expansion of codes for traumatic fractures and other injuries in ICD-10-CM make memorization of the codes very difficult, the format and structure of the codes in chapter 19 provides a conceptual structure that is logical. Each character within a code provides a unique component of the specificity of the code. Within most of chapter 19 the second character identifies the general anatomic site, the third character the general type of injury, the fourth and fifth character further specifies the anatomic site or type of injury and the sixth character identifies the laterality of the injury.

Compare the following two codes for general anatomic site and injury (second and third character)

EXAMPLE

S42.151A Displaced fracture of neck of scapula, right shoulder, initial encounter
 S43.151A Posterior dislocation of right acromioclavicular joint, initial encounter
 S72.251A Displaced subtrochanteric fracture of right femur, initial encounter
 S73.121A Ischiocapsular (ligament) sprain of right hip, initial encounter

Based upon the example, all injuries to the shoulder and upper arm, regardless of the type of injury, will have the second character of 4 while all injuries to the hip and thigh will have the second character of 7. In the third character place all fractures except physeal fractures, are identified by a 2 and all dislocations and sprains of joint and ligaments are identified by a 3.

The principles of multiple coding of injuries should be followed in coding fractures. Fractures of specified sites are coded individually by site in accordance with both the provisions within categories S02, S12, S22, S32, S42, S52, S62, S72, S82, S92, and the level of detail furnished by medical record content.

A fracture not indicated as open or closed should be coded to closed. In ICD-10-CM a fracture not indicated whether displaced or non-displaced should be coded to displaced.

In ICD-10-CM fracture codes have both site and laterality designations as well as added specificity as to the type of fracture. As fractures codes in ICD-10-CM are very specific to type and location for coding purposes. It is important to understand the terminology used in regards to bones and fractures for proper code assignment. Coding of fractures can be complex without the proper anatomy knowledge.

Common terminology:

- Long bones—bones that are longer than they are wide and have a growth plate. Examples include the femur and phalanges.
- Short bones—approximately as wide as they are long and have a primary function of providing support and stability with little movement. Examples include carpals and tarsals.
- Flat bones—strong, flat plates of bone with the main function of providing protection to the bodies' vital organs and being a base for muscular attachment. Examples include the scapula and cranium.
- Irregular bones—bones which do not fall into any other category, due to their nonuniform shape. Examples include the vertebrae and sacrum.
- Sesamoid bones—usually short or irregular bones, imbedded in a tendon. Examples include the patella and pisiform (smallest of the Carpals).
- Diaphysis—shaft of a long bone
- Epiphysis—end of the shaft of a long bone
- Metaphysis—growth plate region
- Condyle—rounded projection on the end of a bone usually at the point of articulation
- Intercondylar—located between two condyles
- Lateral epicondyle—rounded projection of the bone prior to the condyle which serves as a place of attachment of ligaments. The lateral epicondyle is on the lateral side of the bone.
- Medial epicondyle—rounded projection of the bone prior to the condyle which serves as a place of attachment of ligaments. The medial epicondyle is on the medial side of the bone.

- Malunion—faulty union of the fragments of a fractured bone
- Nonunion—failure of the ends of a fractured bone to unite

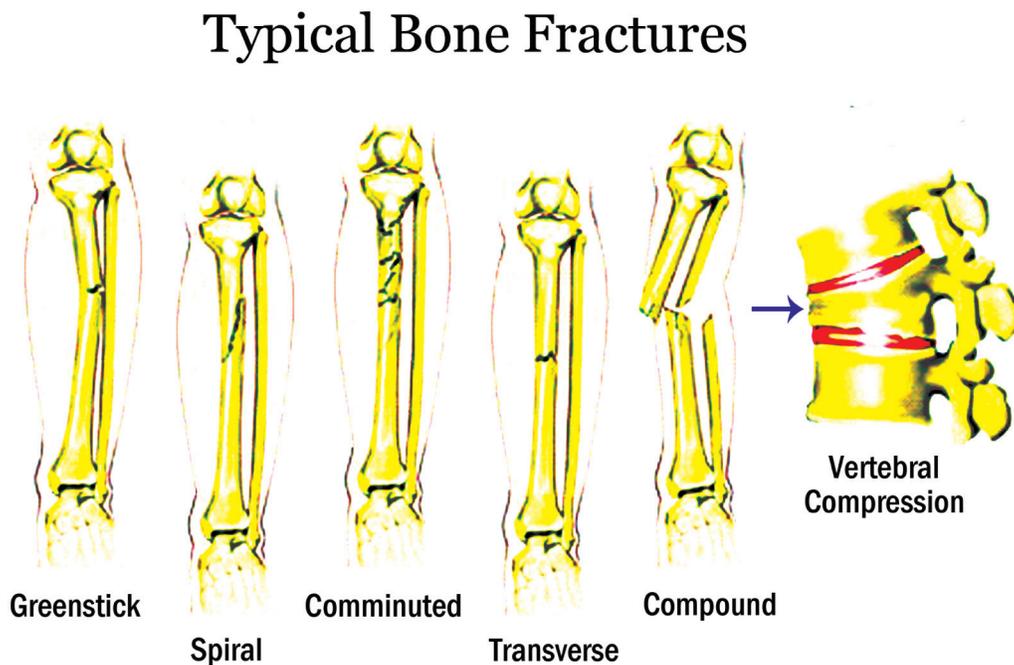
EXAMPLE

Bobby injured his arm during a fall from a tree. After an examination and review of films, he is diagnosed with an extraarticular fracture of the left distal radius.

S52.552A Other extraarticular fracture of the lower end of left radius, initial

W14.XXXA Fall from tree, initial

Below are illustrations of typical fractures.



Source: AAPC

A Greenstick fracture is an incomplete fracture in which the bone is fractured on one side and bent on the other. This type occurs most often in children. Greenstick fractures can take a long time to heal (about 6 weeks) because they tend to occur in the middle, slower growing parts of bone.

A bent bone fracture is a fracture where the bone is bent, creating multiple tiny fractures along the bone. This type of fracture is difficult to diagnosis as the fractures do not show up on X-rays. Bent bone fractures are also known as plastic deformations and most commonly occur in the forearm.

A spiral fracture is a bone fracture caused by a twisting force. It may also be called a torsion fracture. This is a common fracture suffered by people who snow ski.

A comminuted fracture is a fracture in which the bone fragments into several pieces. Comminuted fracture is associated with crush injuries. It is common in the elderly.

EXAMPLE

Charlotte was attempting to keep her 8-year-old grandson from running into the corner of a display case. She struck her right arm on the case which was subsequently struck by his head. She reports the pain was immediate and she was unable to flex her hand without pain. Imaging shows a fracture of the mid radius shaft with comminution of multiple bone fragments and splinters.

S52.351A Displaced comminuted fracture of shaft of radius, right arm, initial encounter

W22.09XA Striking against other stationary object, initial encounter

W50.0XXA Accidental hit or strike by another person, initial encounter

A segmental fracture is a fracture in which the bone breaks into two or more large pieces at the fracture site. This type of fracture frequently causes soft tissue injury and is usually the result of high-energy trauma, such as car accidents.

EXAMPLE

Patient is seen in ED after being involved in a traffic accident with several other vehicles. Imaging shows a three part, displaced segmental fracture of the right femoral shaft.

S72.361A Displaced segmental fracture of the shaft of the right femur, initial encounter
closed fracture

V89.2XXA Person injured in unspecified motor-vehicle accident, traffic, initial encounter

A transverse fracture is a fracture at a right angle to the bone's axis. Most times, transverse fractures occur from some sort of direct blow or heavy repetitive action like running. Transverse fractures often occur in high impact sports and car accidents.

A compound fracture is a fracture in which broken bone fragments lacerate soft tissue and protrude through an open wound in the skin.

A vertebral compression fracture is a fracture that occurs when the bones of the spine become broken due to trauma. Usually the trauma necessary to break the bones of the spine is quite large.

A Monteggia's fracture is a proximal on third fracture of the ulna with an associated dislocation of the head of the radius. This type of fracture is more common in young children and rarely seen in adults.

A Galeazzi's fracture is a fracture of the radius shaft with an associated subluxation or dislocation of the distal ulna. While closed reduction is possible for children with this type of fracture, adults usually require open treatment. Galeazzi's fractures are also known as a reverse Monteggia's fracture.

A torus fracture is a partial fracture where the bone is broken on one side and buckles outward on the other side. This type of fracture is common in children and is also known as a buckle fracture.

An oblique fracture is a fracture running diagonally along the axis of a bone. These types of fracture are the result of trauma that causes the bone to bend and twist resulting in the break.

A burst fracture is a fracture of the vertebra caused by a high-energy axial load. This type of fracture is traumatic and may be the result of auto accidents, falls from height, or high speed. Pieces of the fractured bone may be forced into the surrounding tissue including the spinal canal.

A Colles' fracture is a fracture of the distal end of radius within one inch of the joint. The proximal end of the radial fracture is displaced towards the inside (ventral) of the wrist. This type fracture typically occurs from landing on an outstretched arm, palm down, and is particularly common in patients with osteoporosis.

A Smith's fracture is a fracture of the distal end of the radius. The proximal end of the radial fracture is displaced towards the back (dorsal) of the wrist. This type of fracture is usually caused by landing on an outstretched arm but on the backside of the hand.

A Barton's fracture is an intra-articular fracture of the distal radius with an associated dislocation of the radiocarpal joint.

A bimalleolar fracture is a fracture of both the lateral malleolus and the medial malleolus of the ankle. This type of fracture usually requires open reduction and internal fixation to restore the ankle.

A trimalleolar fracture is a fracture of the lateral malleolus, medial malleolus and the posterior malleolus. Ligament damage associated with the fracture may also be present.

A Maisonneuve's fracture is a fracture of the proximal fibula with an associated tear of the distal tibiofibular syndesmosis and interosseous membrane. Fractures of the distal tibia and medial or lateral malleoli are also associated with this type of fracture as well as a rupture of the deep deltoid ligament. This type of fracture is typically caused by an external rotational force.

A pilon fracture is a comminuted fracture of the tibia near the ankle. Many times there is an associated fracture of the fibula. This type of fracture is caused by high-energy vertical axial loading which may occur due to a fall from height or motor vehicle accident. Pilon fractures are most common in adult males between 35 and 40 years-of-age.

EXAMPLE

While painting his house, Jacob felt the foot of the ladder sink into the ground pitching the ladder to the left, causing him to lose his balance and jump to the ground from two-stories up. He is seen in the ED with right ankle and leg pain. Imaging shows a pilon fracture of the tibia and an associated comminuted fracture of the fibula.

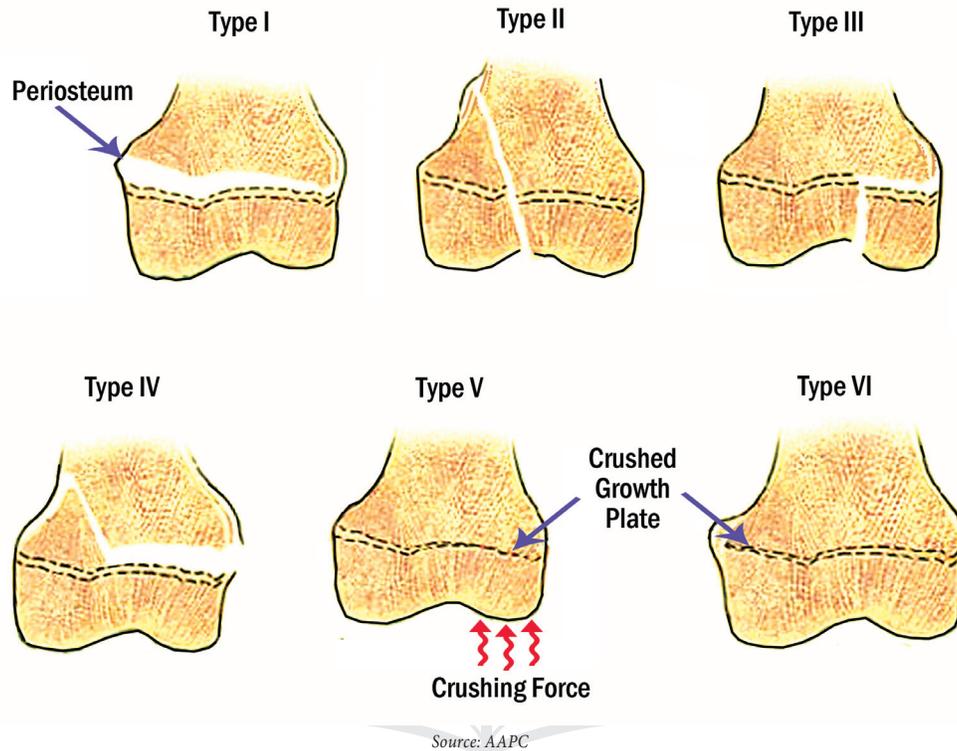
S82.872A Displaced pilon fracture of left tibia, initial encounter for closed fracture

S82.452A Displaced comminuted fracture of shaft of left fibula, initial encounter for closed fracture

W11.XXXA Fall on and from ladder, initial encounter

Another common fracture seen in children is Salter-Harris fracture.

Salter-Harris Fracture Classification



A Salter-Harris fracture is a traumatic fracture of the physal and/or epiphyseal growth plate. Salter-Harris fractures occur in the extremities of children at the point where new bone is being formed as the bones grow.

Type I Growth Plate Fracture:

Type I Salter-Harris fractures tend to occur in younger children. These injuries go directly across the growth plate, and the surrounding bone is not involved. Often, X-rays of a child with a type I growth plate fracture will appear normal. Healing of type I fractures tends to be rapid and complications are rare. Most type I growth plate injuries are treated with a cast.

Type II Growth Plate Fracture:

A type II growth plate fracture starts across the growth plate, but the fracture then continues up through the shaft of the bone (away from the joint). This is the most common type of growth plate fracture, and tends to occur in older children. Type II growth plate fractures usually heal quickly and complications are uncommon.

Type III Growth Plate Fracture:

A type III Salter-Harris fracture begins across the growth plate and continues by turning outward toward the joint and exits out the end of the bone into the joint, disrupting the cartilage. This type of fracture tends to occur in older children.

Type IV Growth Plate Fracture:

A type IV Salter-Harris fracture transects the growth plate with a fracture to the bone on each side of the growth plate. This type of fracture can affect the cartilage of the joint and may impair bone growth.

Type V Growth Plate Fracture:

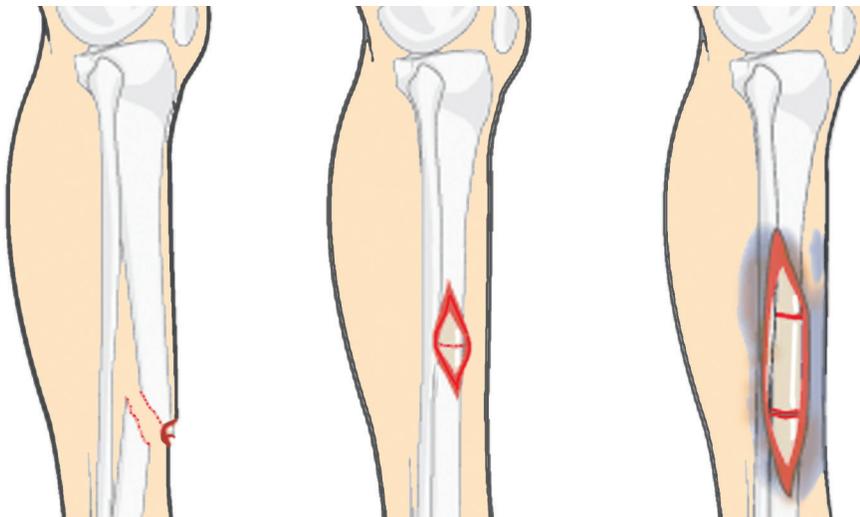
A type V Salter-Harris fracture is the result of a crushing injury to the growth plate and end of the bone. This type of fracture may cause permanent damage to the growth plate affecting bone growth and limb alignment.

EXAMPLE

15-year-old Sarah presents with a displaced fracture of the left distal femur. Plain films reviewed, the fracture is found to be within the growth plate continuing proximally approximately 12 cm through the diaphysis.

S79.122A Salter-Harris Type II physeal fracture of lower end of left femur, initial encounter for closed fracture

Open fractures are classified with the Gustilo classifications in ICD-10-CM. Gustilo open fracture classification classifies fractures into three major categories depending on the mechanism of the injury, soft tissue damage and degree of skeletal involvement. The categories are Type I, Type II, and Type III. Type III is further subdivided into IIIA, IIIB, or IIIC. The higher up in the category, the worse the fracture and the more serious the injury.



Source: AAPC

Type I

The wound is less than 1 cm with minimal soft tissue injury, wound bed is clean. The fracture is usually a simple transverse, short oblique fracture, or with minimal comminution.

Type II

The wound is greater than 1 cm with moderate soft tissue injury. The fracture is usually a simple transverse, short oblique fracture, or with minimal comminution.

Type III

Fractures that involve extensive damage to the soft tissues, including muscle, skin, and neurovascular structures (gunshot wounds, neurovascular injury, farm injuries with soil contamination, and traumatic amputations)

Type IIIA

Adequate soft tissue coverage despite soft tissue laceration or high-energy trauma irrespective of size of wound, and includes segmental or severely comminuted fractures.

Type IIIB

Extensive soft tissue loss with periosteal stripping and bony exposure usually associated with massive contamination.

Type IIIC

Major arterial injury repair is required for limb salvation.

EXAMPLE

Patient is seen in emergency department following a motor vehicle accident. Patient was attempting to exit his car when it was struck by another car. He was not fully out of the vehicle, and the resulting impact caused the door to slam shut on his right forearm where it was wedged until assistance arrived.

Assessment: Displaced transverse fracture of right ulna. Open fracture of radius with extensive comminution of the distal shaft fracture. There is also injury due to bone fragments of abductor pollicis longus muscle and possible the laceration of the extender carpi radialis brevis tendon.

S52.351C Displaced comminuted fracture of the shaft of radius, right arm, initial encounter for open fracture type IIIA

S52.221C Displaced transverse fracture of shaft of right ulna, initial encounter for open fracture type IIIA

V43.42XA Person boarding or alighting a car injured in collision with other type car

Initial vs. Subsequent Encounter for Fractures

Most categories in chapter 19 have seventh character extensions that are required for each applicable code. Most categories in this chapter have three extensions (with the exception of fractures): A, initial encounter; D, subsequent encounter, and S, sequela.

CODING TIP

Remember, the seventh character must always be the seventh character in the data field. If a code that requires a seventh character is not six characters in length, a placeholder X must be used to fill in the empty characters.

Traumatic fractures are coded using the appropriate seventh character extension for initial encounter (A, B, C) while the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

A initial encounter for closed fracture

B initial encounter for open fracture type I or II or initial encounter for open fracture NOS

C initial encounter for open fracture type IIIA, IIIB, or IIIC

EXAMPLE

A patient was seen and treated for an open burst fracture of the first lumbar vertebra, which became unstable.

S32.012B Unstable burst fracture of first lumbar vertebra

Note: The seventh character B identifies the initial encounter for the open fracture

CODING TIP

Don't latch on to the word "initial" as this could hinder your appropriate selection. Instead keep in mind the words "active treatment" as identified in the guidelines.

After the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase, fractures are coded using the appropriate seventh character extension for subsequent care (D, E, F). An encounter for the care of fractures taking longer than normal to heal should be coded using the seventh character extension for delayed healing (G, H, J). Examples of subsequent care are: routine cast changes or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow-up visits following treatment of the injury.

G subsequent encounter for closed fracture with delayed healing

H subsequent encounter for open fracture type I or II with delayed healing

J subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing

Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate seventh character extensions for subsequent care with nonunion (K, M, N) or subsequent care with malunion (P, Q, R).

K subsequent encounter for closed fracture with nonunion

M subsequent encounter for open fracture type I or II with nonunion

N subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion

P subsequent encounter for closed fracture with malunion

Q subsequent encounter for open fracture type I or II with malunion

R subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion

EXAMPLE

An out of town patient presents to the ED for a recheck of her closed fracture of the neck of the left radius. X-rays are taken and show a malunion of the fracture.

S52.132P Displaced fracture of neck of left radius, subsequent encounter for closed fracture with malunion

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes. The aftercare Z codes should not be used for aftercare for traumatic injuries. For aftercare of a traumatic fracture, assign the acute fracture code with the appropriate seventh character.

The 7th character extension S, sequela, is for use with complications or conditions that arise as a direct result of an injury, such as osteonecrosis or post traumatic osteoarthritis. The necrosis of the bone is a sequelae of the fracture. When using extension S, it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The S is added only to the injury code, not the sequela code. The S extension identifies the injury responsible for the sequela. The specific type of sequela (eg, osteonecrosis) is sequenced first, followed by the injury code.

EXAMPLE

Sunday morning William presents to the ED with increasing right shoulder joint pain and a decrease in the previous range of motion for the same. He was seen in orthopaedics six months ago for a comminuted fracture of the right proximal humeral shaft, which subsequently healed nicely. X-rays now show necrosis of the humeral head.

M87.221 Osteonecrosis due to previous trauma, right humerus

S42.351S Displaced comminuted fracture of shaft of humerus, right arm, sequela

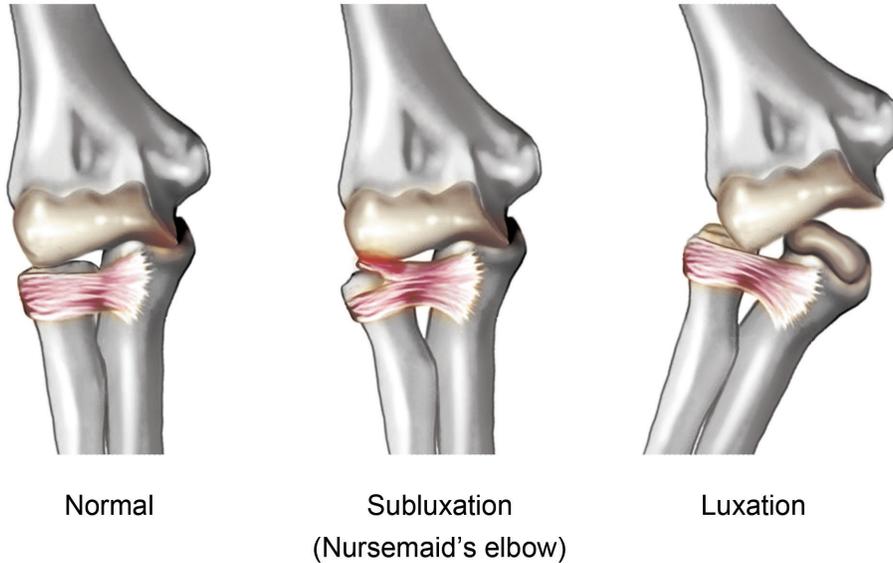
Fractures Sequencing

Multiple fractures are sequenced in accordance with the severity of the fracture. The provider should be asked to list the fracture diagnoses in the order of severity.

Dislocations

As with the codes for fractures, coding dislocations in ICD-10-CM have greatly expanded to include the joint dislocated, laterality, extent, position of the dislocation, and seventh character extender additions.

Joint Luxation and Subluxation

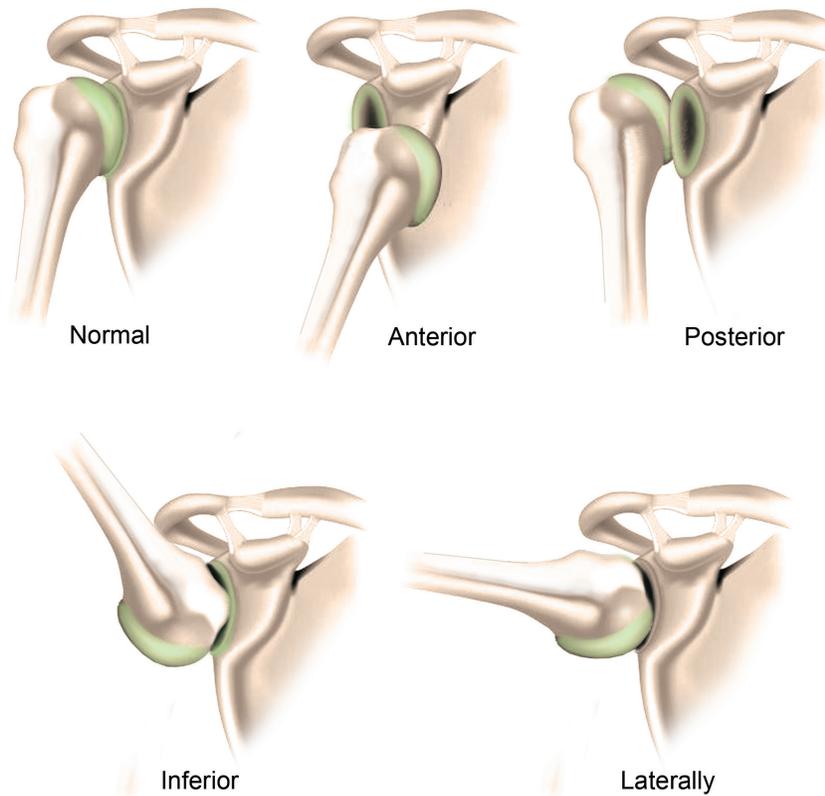


Source: AAPC

To assign a code for dislocation to the highest level of specificity the documentation must include:

- Extent of the dislocation—
 - Subluxation—partial or incomplete dislocation of joint
 - Dislocation—is a complete dislocation of the joint and is also known as luxation of the joint
 - Percentage—Dislocations of certain joints are further classified by the extent based upon percentage of the dislocation.

Dislocation Positions



Source: AAPC

Certain dislocation subcategories are further classified by the position of the dislocation:

- Anterior—The end of the bone is displaced to the anterior, medial and slightly inferior to its normal anatomic position.
- Posterior—The end of the bone is displaced posterior to the joint and its normal anatomic position.
- Inferior—The end of the humerus is forced against the acromion causing the arm to lock in an upward and backward position.
- Laterally—The end of the bone is displaced outwardly (laterally) to the joint and its normal anatomic position.

EXAMPLE

10-year-old Sara jumped from her swing while she was on a swing set. She states she landed on her feet but fell forward and landed on her outstretched right arm. When she stood up she had pain at her shoulder and was unable to lift her arm. Plain films were completed.

Assessment: Anterior partial dislocation of right humerus

S43.011A Anterior subluxation of right humerus, initial encounter

ICD-10-CM is less specific than ICD-9-CM in the coding of open versus closed dislocations. In ICD-10-CM open or closed is no longer a combination code when coding for dislocations. Instead, ICD-10-CM includes an instructional note at the beginning of each category of dislocation (S03, S13, S23, S33, S43, S53, S63, S73, S83, S93) that informs the user to code separately any associated open wound.

EXAMPLE

Jessie was knocked down while feeding her pigs on the farm. She attempted to catch herself on her outstretch left forearm resulting in an open anterior dislocation of the left humerus.

ICD-9-CM: 831.11 Anterior dislocation of humerus, open

ICD-10-CM: S43.015A Anterior dislocation of left humerus, initial encounter

S41.042A Puncture wound with foreign body of left shoulder, initial encounter

Traumatic Connective Tissue and Muscle Injuries

Connective tissues within the musculoskeletal system work with the muscles and bones to aid in the production of movement, dictate your degree of flexibility, and protect surrounding tissue during muscle movement.

For proper code assignment in ICD-10-CM it is important to understand the terminology used in regard to both connective tissue and muscles.

Common terminology

- Fascia is a thin membrane surrounding the muscles, tendons, bones, and other organs and tissues. In the musculoskeletal system it protects tissues around muscles during movement.
- Cartilage is a tough flexible tissue found in many places throughout the body. In relation to orthopaedics, cartilage covers and protects the end of the bone at the joint and allows the bones to articulate smoothly.

EXAMPLE

While playing basketball with some friends, Tim was attempting to pivot around another player when he bumped into them and lost his balance, placing his weight on the pivoting left foot and wrenching his knee. He was seen in the ED. MRI studies show a complex tear of lateral meniscus.

S83.272A Complex tear of lateral meniscus, current injury, left knee, initial encounter

W51.XXXA Accidental striking against or bumped into by another person, initial encounter

Y93.67 Activity, basketball

- Tendons are strong cords that attach muscle to bone at the point of insertion. They aid in movement as the muscle at the origin of the tendon is flexed.
- Ligaments, like tendons are tough cords that connect bone to bone. Ligaments provide stability to joints by holding the end of bones in place at the joint.
- Flexor muscles contract to bend a body part at the joint.

- Extensor muscles contract to straighten a body part at the joint.
- Adductor muscles are the muscles that contract to bring a body part (limb) toward the median line of the body. These include the adductor brevis, adductor magnus, and adductor longus of the thigh.

Injuries to the muscles or tendons in ICD-10-CM are classified by the laterality, site, and type of injury; strain, laceration, or other injury. In categories S56, S66, and S96 the codes for injuries of the tendon or muscle are further classified by whether the muscle injured is a flexor or extensor muscles. Certain codes in categories S76 and S86 are further classified by the specific tendon or by muscle specified by type (adduction), name (quadriceps), or location (anterior, posterior).

EXAMPLE

James has a two-day history of right groin pain. He states he woke up with the pain Sunday and it has continued since that time. Upon exam the area does not appear red or hot to touch. There is minor swelling in the area and there is pain to the touch. Movement is localized to the inner thigh.

Assessment: Strained groin muscle.

S76.211A Strain of adductor muscle, fascia and tendon of right thigh, initial encounter

- Strains are an injury to the muscle and/or tendon
- Sprains are a tear or stretch of the ligament. Sprains are graded on a level of severity:
 - Grade 1—Mild damage to the ligament resulting from a slight stretch. The ligament is still able to hold the joint in correct anatomic position.
 - Grade 2—Partial tear of the ligament resulting from a stretch that cause the ligament to become loose.
 - Grade 3—Complete tear of the ligament resulting in instability of the joint

ICD-10-CM does not classify sprains by degree or grade. When documentation includes the grade or degree of sprain it is coded to the specific site and laterality of the injury.

ICD-10-CM groups traumatic injuries such as tears, avulsions, and ruptures of the ligament under the condition of sprain. Sprains are further classified by laterality and the ligament or joint injured.

EXAMPLE

While playing soccer at school, Keegan attempted to retrieve the ball and collided with an opposing team player. Upon attempting to stand he states he immediately felt pain upon standing and ambulating. MRI was reviewed and demonstrates a partial PCL tear of the right knee.

S83.521A Sprain of the posterior cruciate ligament of the right knee, initial encounter

W51.XXXA Accidental striking against or bumped into by another person, initial encounter

Y93.66 Activity soccer

Superficial Injuries

Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.

Primary Injury with Damage to Nerves and/or Blood Vessels

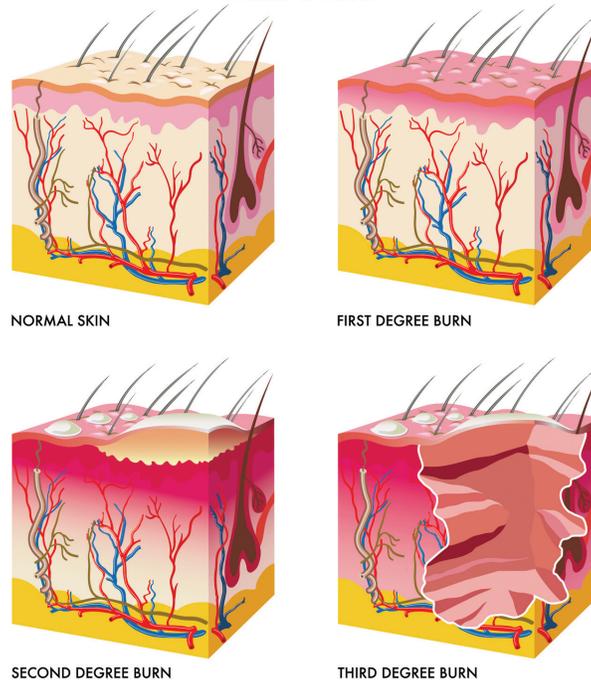
When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) for injury to blood vessels. When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

Coding of Burns and Corrosions

The ICD-10-CM makes a distinction between burns and corrosions. The burn codes are for thermal burns, except sunburns, that come from a heat source, such as a fire or hot appliance. The burn codes are also for burns resulting from electricity and radiation. Corrosions are burns due to chemicals. The guidelines are the same for burns and corrosions.

Current burns (T20–T25) are classified by depth, extent and by agent (X code). Burns are classified by depth as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement). Burns of the eye and internal organs (T26–T28) are classified by site, but not by degree.

Skin Burns



Source: AAPC

Sequencing of Burn and Related Condition Codes

Sequence first the code that reflects the highest degree of burn when more than one burn is present.

EXAMPLE

Patient presents to the emergency room after burning herself with coffee. She has a second degree burn on her right forearm and a first degree burn on her right wrist.

T22.211A Burn of second degree of right forearm, initial encounter

T23.171A Burn of first degree of right wrist, initial encounter

X10.0XXA Contact with hot drinks, initial encounter

Burns of the Same Local Site

Classify burns of the same local site (three-character category level, T20–T28) but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis.

EXAMPLE

A patient presents to the ED with her son. He burned his thigh with a lighter. He has first and second degree burns to his left thigh.

T24.212A Burn of second degree of left thigh, initial encounter

X08.8XXA Exposure to other specified smoke, fire and flames

Non-Healing Burns

Non-healing burns are coded as acute burns. Necrosis of burned skin should be coded as a non-healed burn.

Infected Burn

For any documented infected burn site, use an additional code for the infection.

Assign Separate Codes for Each Burn Site

When coding burns, assign separate codes for each burn site. Category T30, Burn and corrosion, body region unspecified, is extremely vague and should rarely be used.

EXAMPLE

Patient presents for follow up on his burns. He has a healing second degree burn on his right palm and he wants to discuss the scar contracture on his left forearm from a second degree burn.

T23.251D Burn of second degree of right palm, subsequent encounter

L90.5 Scar conditions and fibrosis of skin

T22.212S Burn of second degree of left forearm, sequela

External Cause Codes

The guidelines also give directives on the use of the external cause codes with injuries. The external cause code (how the injury occurred) should be reported with the appropriate seventh character for each encounter for which the injury or condition is being treated.

Codes from category Y92, Place of occurrence of external cause, are to be reported only once at the initial encounter for treatment. These codes indicate where the patient was when the injury happened. The guidelines state if the place of occurrence is not known you would not use the unspecified code for location.

Codes from category Y93, Activity code, are to be reported only once at the initial encounter for treatment. These codes indicate what the patient was doing when the injury happened. The guidelines state if the activity of the patient is not known you would not use the unspecified code for location.

Codes from category Y99, External cause status, should be reported only once at the initial encounter for treatment. These codes indicate the work status of the patient when the injury occurred. The guidelines state if the work status of the patient is not known you would not use the unspecified code for external cause status.

EXAMPLE

A patient presents after cutting herself while washing dishes in the kitchen of her apartment after dinner. Patient states that she put her hand in the dishwasher and grabbed a steak knife. She ran the sponge down the knife to clean it, thinking it was turned down, but it was not. She comes to the surgical center with a laceration without foreign body to the palm of her left hand. Wound was cleaned and sutures were placed.

S61.412A Laceration without foreign body of left hand, initial encounter

W26.0XXA Contact with knife, initial encounter

Y92.030 Apartment as the place of occurrence of the external cause

Y93.G1 Activity, food preparation and clean up