Don't Be Intimidated by ICD-10-CM Changes

A systematic look at the code update in orthopaedics

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The 2,000 new ICD-10-CM (International Classification of Diseases, 10th edition, Clinical Modification) codes that go into effect Oct. 1, 2016, shouldn't send you into a panic. The changes, when analyzed and approached systematically, are not overwhelming.

This article addresses changes in the musculoskeletal and injury chapters that affect orthopaedics. It does not cover editorial changes, additional punctuation, and codes not typically used by orthopaedic surgeons. Keep this article handy while examining the entire list of code changes in these two chapters. ICD-10-CM updates for FY 2017. https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-CM-and-GEMs.html

Choose the option "2017 Addendum," then "tabular addenda."

Gout

The "excludes 1" note for the *M1A–Chronic Gout* and the *M10–Gout* code categories has been eliminated. The "excludes 1" note indicated that the two listed codes should never be reported together and prevented the reporting of acute and chronic gout concurrently. These categories now have an "excludes 2" note, so the two codes can be used together if both conditions exist at the time.

Code for chronic gout (M1A) and acute gout attack (M10.-) in the same episode of care. Sequencing instructions are to list the acute code (M10.-) first, followed by the chronic gout code (M1A.-).

Bunions and bunionettes

M21.61–Bunion was added as a unique code with a sixth character addressing laterality (1 = right, 2 = left, and 9 = unspecified). When addressing laterality, "unspecified" means that the documentation does not specify right or left; it should be used only when it is not possible to ascertain the specific information. Coders should query the provider for laterality and update the record to include this information. Reporting a bunion using code *M20.1–Hallux valgus (acquired)* is no longer correct.

M21.62–Bunionette is a new code. Bunionettes were previously reported using *M20.5–Other deformities of toe(s) (acquired).* For bunionettes, a sixth character addressing laterality is required (1 = right, 2 = left, and 9 = unspecified).

Pain in joint
An additional location—the hand—has been added to *M25.5–Pain in joint.* Use M25.54 with a sixth character for laterality to indicate pain in joints of the hand (M25.541–Pain in joints of right hand; M25.542–Pain in joints of left hand; M25.549–Pain in joints of unspecified hand).

With this addition, the locations for joint pain include shoulder, elbow, wrist, hand, hip, knee, ankle, and foot.

Cervical disk disorders
In the section (M50) addressing cervical disk disorders, ICD-10-CM makes consistent changes throughout the category in the midcervical range. Previously, the midcervical region included all levels (C4-C5, C5-C6, C6-C7). Effective Oct. 1, 2016, each midcervical level has a specific code for each type of cervical disk disorder. [Table 1 http://www.aaos.org/uploadedFiles/Periodical_Content/AAOSNow/2016/Oct/managing/article_images/managing01_t1.pd](http://www.aaos.org/uploadedFiles/Periodical_Content/AAOSNow/2016/Oct/managing/article_images/managing01_t1.pd)

shows the impact of this change for *M50.02–Cervical disk disorder with myelopathy.*

The addition of specific codes addressing each of the midcervical levels is consistent for each disorder in this category, including the following: myelopathy, radiculopathy, displacement, degeneration, other and unspecified cervical disk disorders. No changes were made to disk disorders that occur at the high cervical and cervicothoracic regions.

Other muscle disorders
In the category *M62–Other disorders of muscle,* the code *M62.84–Sarcopenia* was added to include age-related sarcopenia. The instructions state that any underlying disease (if applicable) should be coded first.

Fractures
A new code category for nontraumatic femoral fractures was added to *M84–Disorder of continuity of bone.* Atypical femoral fractures should include the appropriate seventh character options. See [Table 2](#)

 http://www.aaos.org/uploadedFiles/Periodical_Content/AAOSNow/2016/Oct/managing/article_images/managing01_t2.pd

for a complete listing for this category.

ICD-10-CM does not define atypical femoral fractures, but these are typically low-energy fractures without the presence of malignancy that can occur with long-term use of bisphosphonates. Incomplete, nondisplaced atypical femur fractures are often fixed before a complete fracture occurs and are frequently seen on the contralateral limb of a patient with a complete fracture.

Note that this code category differentiates between incomplete and complete fractures, in addition to laterality. Complete fractures also specify the fracture pattern as transverse or oblique. Although the category does not include instructions to "use additional code, if applicable, to identify" long-term use of specific drugs, from an orthopaedic perspective, the following additional codes would be germane:

- Z79.83–Long term (current) use of bisphosphonates
- Z79.890–Hormone replacement therapy (postmenopausal)

- M96–Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified

The latest version of ICD-10-CM separates postprocedural hemorrhage from postprocedural hematoma and gives each a unique code. A new code for postprocedural seroma was added to the list of complications. These codes are listed in Table 3.
http://www.aaos.org/uploadedFiles/Periodical_Content/AAOSNow/2016/Oct/managing/article_images/managing01_t3.pdf

M97–Periprosthetic fracture around internal prosthetic joint is not a new code category; it was relocated from chapter 19 (Injury, Poisoning, and Certain Other Consequences of External Causes) to chapter 13 (Diseases of the Musculoskeletal System). Previously, periprosthetic fractures were coded as T84.0–Mechanical complications of internal joint prosthesis, with specific codes for hip and knee joint prosthesis.

M97–Periprosthetic fracture around internal prosthetic joint requires specific codes for laterality. The number of locations has been expanded and includes the following: hip, knee, ankle, shoulder, elbow, and "other" with notation that "other" includes finger, spinal, toe, and wrist joints. See Table 4
http://www.aaos.org/uploadedFiles/Periodical_Content/AAOSNow/2016/Oct/managing/article_images/managing01_t4.pdf

for a listing of these codes.

Remember that the codes for periprosthetic fracture in this category should not be used to report fracture of the bone following insertion of an orthopaedic implant, joint prosthesis, or bone plate (M96.6_), or breakage or fracture of the implant (T84.01_). This instruction is unchanged from the previous version of ICD-10-CM.

Other mechanical complications of internal joint prostheses (broken prosthesis, dislocation, mechanical loosening, and periprosthetic osteolysis and wear) remain in the T84.0 code category of the injury chapter.

Concussion codes
All of the codes that address concussion with loss of consciousness of 31 minutes and greater have been eliminated from category *S06.0–Concussion.* This leaves only the following two codes in this category:

- S06.0X0–Concussion without loss of consciousness
- S06.0X0–Concussion with loss of consciousness, 30 minutes or less

The "excludes 1" note in this category was expanded and instructs the user that if concussion occurs with other intracranial injuries, the specific intracranial injury should also be reported. These injuries include traumatic cerebral edema, diffuse traumatic brain injury, focal traumatic brain injury, contusion and laceration, traumatic hemorrhage, and other specified intracranial injuries. These intracranial injuries still have the highly specific time breakdowns for loss of consciousness that were deleted from the concussion codes.

Foot
S92.81–Other fracture of foot was added with a note to indicate that this includes sesamoid

fractures of the foot. A sixth character addressing laterality is required: 1 = right, 2 = left, and 9 = unspecified.

The following three new code subcategories addressing physeal fractures of the ankle and foot were added:

- S99.0–Physeal fracture of **calcaneus**
- S99.1–Physeal fracture of **metatarsal**
- S99.2–Physeal fracture of phalanx of toe

Each of these subcategories has a full complement of Salter-Harris (types I–IV) and laterality-specific codes.

T codes
All codes under T84.04–Periprosthetic fracture around internal prosthetic joint were deleted because this entire category was moved to category M97–Periprosthetic fracture around internal prosthetic joint, as indicated above. All other mechanical complications of internal joint prostheses (broken prosthesis, dislocation, mechanical loosening, and periprosthetic osteolysis and wear) remain in the T84.0 code category in chapter 19.

Under T85.1–*Mechanical complication of implanted electronic stimulator of nervous system,* specific codes to identify the mechanical complication (breakdown, displacement, and other) were added for "generator." These codes are in addition to the existing codes for mechanical complication of the "electrode" and "lead."

The following specific codes to identify the specific mechanic complication were added to *T85.6–Mechanical complication of other specified internal and external prosthetic devices, implants, and grafts:*

- T85.615–Breakdown (mechanical) of other nervous system device, implant or graft
- T85.625–Displacement of other nervous system device, implant or graft
- T85.635–Leakage of other nervous system device, implant or graft
- T85.695–Other mechanical complication of other nervous system device, implant or graft

The following new, specific codes for nervous system devices were added to *T85.7–Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts* to identify location:

- T85.730–Infection and inflammatory reaction due to ventricular intracranial (communication) shunt
- T85.731–Infection and inflammatory reaction due to implanted electronic neurostimulator of brain, electrode (lead)
- T85.732–Infection and inflammatory reaction due to implanted electronic neurostimulator of peripheral nerve, electrode (lead)
- T85.733–Infection and inflammatory reaction due to implanted electronic neurostimulator of spinal cord, electrode (lead)
- T85.734–Infection and inflammatory reaction due to implanted electronic neurostimulator generator
- T85.735–Infection and inflammatory reaction due to cranial or spinal infusion catheter

- T85.738–Infection and inflammatory reaction due to other nervous system devices, implants and grafts

T85.8–Other specified complication of internal prosthetic devices, implants and grafts, not elsewhere classified now has specific codes for nervous system devices and other internal prosthetic devices for each of the following listed complications: embolism, fibrosis, hemorrhage, pain stenosis, thrombosis, and other.

Finally, the following code was added under T88.5–Other complications of anesthesia:

- T88.53–Unintended awareness under general anesthesia during procedure

Cautions
Remember that this review does not cover every edit, added notation, or new code. The entire 2017 addendum to ICD-10-CM is available on the Medicare website (see online version for direct link). Review the changes and ensure that outdated or deleted codes are not used after the implementation date, which can result in potential claims delays or denials.

It is important that electronic health record systems include these edits by Oct. 1, 2016, when these codes go into effect.

Medicare will begin requiring the highest level of specificity for ICD-10-CM codes beginning Oct. 1, 2016. The "frequently asked questions" posted on the Centers for Medicare & Medicaid Services website on Aug. 18, 2016, make it clear that the year of leniency is coming to a close. No extension and no "phase-in" of the requirement to use the most specific ICD-10 diagnosis code will be allowed.

The website states that "providers will be required to code to accurately reflect the clinical documentation in as much specificity as possible, as per the required coding guidelines." Surgeons who use codes such as *M16.9–Osteoarthritis of hip, unspecified* or *MO6.9–Rheumatoid arthritis, unspecified* will begin to see denials after Oct. 1. Details such as laterality will be required in the documentation and must be reflected in the specific diagnosis code submitted on the claim. Providers must be prepared for Medicare and other payers to turn up the heat on claim edits.

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