Disclaimer

The National Academy of Chiropractic Coders, denies responsibility or liability for any erroneous opinions, analysis, and coding misunderstandings on behalf of individuals undergoing this ICD-10-CM study program.

The coding topics taught here are for the sole purpose of the chiropractic profession, any transference to other healthcare disciplines are at the risk of the individual coder’s discretion.

We have based the majority of this program on the guidelines set forth by the CPT Code Book, ICD-10-CM information found in the ChiroCode DeskBook, and in The Medicare Manual, as it relates to Chiropractic practice.

No legal advice is given in this presentation, and we encourage you to refer any such questions to your healthcare attorney.
The Language of Coding

Coding is the uniform language that conveys medical information

Coding is organized alphanumerically. When used properly, coding gives a description of the diagnosis, medical procedure or supply
Chiropractic coding will mainly consist of work with the musculoskeletal and neurological systems.
History of ICD

☑ Began after World War II
☑ Developed by the World Health Organization (WHO)
☑ Usually a new release every 10 years
☑ ICD-9 delayed by 5 years, arriving in 1975
☑ ICD-10 came on in 1990 in all other major countries but the USA
☑ ICD-11 is already under development, arrival 2020?
What else is Affected?

**HIPAA Electronic Transaction Standards**

The new version of the standard for electronic health care transactions (Version 5010) is essential to the use of ICD-10 codes because the current standard (Version 4010/4010A1), cannot accommodate the use of the greatly expanded ICD-10 code set. This has already happened kind...
1) All services and discharges on or after **October 1, 2015** must be coded using the ICD-10 code set. The necessary system and workflow changes need to be in place by the compliance date in order for you to send and receive the ICD-10 codes.
Introduction to ICD-10-CM

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is a newer U.S. version of the World Health Organization’s set of diagnosis codes, which will be adopted in the United States effective October 1, 2014.
If it Were Only That Simple

Diagnosis created by Doctors must be entered into the practice management system precisely for the following reasons:

➢ Ensures clearly recognizable conditions
➢ Used for statistical analysis
➢ Drives many laws & regulations regarding public health and safety
Healthcare & Numbers

- Numbers play a vital role in healthcare

- CPT-Current Procedural Terminology Codes
- HCPCS-Supply Codes
- Tax I.D. Numbers
- NPI
- PQRS
- EHR Stimulus
Hello ICD-10-CM

- Originally developed in the early 1990’s
- The switch was not feasible with mainframe computers of the time
- Complete overhaul from 5 numbers to alphanumeric and 7 spaces
- 17,000 codes (ICD-9) to 70,000 (ICD-10)
- Specificity should = medical necessity
ICD-10 has 3 volumes

1. Volume 1—Tabular lists for cause of death and codes
2. Volume 2—Descriptions, guidelines, and coding rules
3. Volume 3—Alphabetical index to diseases and nature of injury

*Coding Pearl—always code from the tabular list*
What’s Wrong with ICD-9?

- We have outgrown ICD-9
- New Sub-specialties
- No codes to correlate clinical findings
- ICD-9 is full
## Let’s Compare: ICD-9 vs. ICD-10

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lacks detail</td>
<td>Very VERY VERY specific</td>
</tr>
<tr>
<td>17 chapters, almost 17,000 codes</td>
<td>21 chapters, almost 68,000 codes</td>
</tr>
<tr>
<td>3-5 digits, decimal a/f 3rd digit</td>
<td>3-7 digits, decimal a/f 3rd digit</td>
</tr>
<tr>
<td>1st digit alpha (E/V) or numeric; digit 2-5 numeric</td>
<td>1st digit alpha; digit 2 numeric, digit 3-7 alpha-numeric</td>
</tr>
<tr>
<td>Lacks laterality</td>
<td>Has laterality</td>
</tr>
<tr>
<td>Limiting in ability to expand</td>
<td>Adaptive for future technology</td>
</tr>
<tr>
<td>Less specific codes limit data for research</td>
<td>Specificity improves coding accuracy</td>
</tr>
<tr>
<td>Difficult to analyze data</td>
<td>Details provide data for statistical analysis and research</td>
</tr>
<tr>
<td>Does not support interoperability b/c it is not used by other countries</td>
<td>Supports exchange of health data b/t other countries</td>
</tr>
</tbody>
</table>
How will the New Codes Work?

- Injury codes now by site instead of injury type
- Expandable
- Higher specificity and uses current terminology
- Allows for statistical analysis
- 7th character can represent visit encounters or sequelae for injuries and external causes
- Codes assigned to each chapter are broken into blocks of one or more 3 digit codes each. Each block deals with a specific disease and associated symptoms
How will the New Codes Work?

- 3-7 characters in length – each added digit adds specificity to the code.
- Character 1 is always alpha
- Character 2 is always numeric
- Character 3-7 are alpha numeric
- Some codes will use “x” as a place holder for characters 4-6 when needed
- 7th character is used for certain sections (e.g. musculoskeletal, injuries and external causes of injury)
### Code Structure of ICD-10-CM versus ICD-9-CM

ICD-10-CM codes may consist of up to seven digits, with the seventh digit extensions representing visit encounter or sequelae for injuries and external causes.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="ICD-9-CM Format" /></td>
<td><img src="image2" alt="ICD-10-CM Format" /></td>
</tr>
</tbody>
</table>

- **category**
- **etiology, anatomic site, manifestation**

- **category**
- **etiology, anatomic site, severity**
- **extension**
How are ICD-9 and ICD-10 different?

ICD-9

- Numeric or Alpha (E or V)
- Numeric

ICD-10

- Alpha (every letter except U)
- Numeric
- Numeric or Alpha (every letter except U)

- Category
- Category, anatomic site, severity
- Extension
ICD-10-CM code for chronic gout due to renal impairment, left shoulder, without tophus.
<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>739.1 Segmental Dysfunction Cervical Spine</strong></td>
<td><strong>M99.01 Segmental &amp; Somatic Dysfunction Cervical</strong></td>
</tr>
<tr>
<td>839.01 Subluxation of First Cervical</td>
<td>S13.111_ Dislocation of C0/C1 Cervical Vertebrae</td>
</tr>
<tr>
<td>723.1 Cervicalgia</td>
<td>M54.2 Cervicalgia</td>
</tr>
<tr>
<td>722.52 Degeneration of Lumbar/Lumbosacral Disc</td>
<td>M51.36 Other Intervertebral disc degeneration Lumbar</td>
</tr>
<tr>
<td></td>
<td>M51.37 Other Intervertebral disc degeneration Lumbosacral region</td>
</tr>
<tr>
<td>A. Date of Current Illness, Injury, or Pregnancy (LMP)</td>
<td>B. Other Date</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>MM DD YY</td>
<td>MM DD YY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>17a. Name of Referring Provider or Other Source</th>
<th>17b. NPI</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>19. Additional Claim Information (Designated by NUCC)</th>
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</table>

<table>
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<tr>
<th>20. Outside Lab?</th>
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<tbody>
<tr>
<td>YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>21. Diagnosis or Nature of Illness or Injury</th>
<th>ICD Ind.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>B.</td>
</tr>
</tbody>
</table>

|-----------------------|-------------------|

<table>
<thead>
<tr>
<th>23. Prior Authorization Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>24. Date(s) of Service From To</th>
<th>B. Place of Service</th>
<th>C. Procedures, Services, or Supplies (Explain Unusual Circumstances)</th>
<th>D.</th>
<th>E. Diagnosis Pointer</th>
<th>F. Days of Supply</th>
<th>G. Diagnosis Pointer</th>
<th>H. Epsdt Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td>MM DD YY</td>
<td>PLACE OF EMG</td>
<td>CPT/HCPCS</td>
<td>MODIFIER</td>
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</tbody>
</table>

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>SSN</td>
<td>EIN</td>
<td>YES</td>
<td>NO</td>
<td>S</td>
<td>S</td>
</tr>
</tbody>
</table>
CMS-1500 Claim form

Revision 02/12

• Changed to match the electronic format (5010) and ICD-10 codes
• Adds space for eight more diagnosis codes in box 21.
• January 6th, 2014 - Health plans and clearinghouses must accept the form.
• April 1st, 2014 – Providers must use the new form
SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered “incident to” a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental, part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.
ICD-10 Rules

The chapters are as follows:

- Chapter 1. Certain Infectious and Parasitic Diseases (A00-B99)
- Chapter 2. Neoplasms (C00-D49)
- 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)
ICD-10 Rules

- Chapter 8: Disease of the Ear and Mastoid Process (H60-H95)
- Chapter 9: Diseases of the Circulatory System (I00-I99)
- Chapter 10: Diseases of the Respiratory System (J00-J99)
- Chapter 11: Diseases of the Digestive System (K00-K94)
- Chapter 12: Diseases of the Skin and Subcutaneous Tissue (L00-L99)
- Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99) – main one for chiropractic.
- Chapter 14: Diseases of the Genitourinary System (N00-N99)
- Chapter 15: Pregnancy, Childbirth and the Puerperium (O00-O99)
ICD-10 Rules

Chapter 16: Certain Conditions Originating in the Perinatal Period (P00-P96)
Chapter 17: Congenital Malformations, Deformations and Chromosomal Abnormalities (Q00-Q99)
Chapter 18: Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)
Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88)
Chapter 20: External Causes of Morbidity (V01-Y99)
Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99).
ICD-10 Rules

“SYMBOLS and CONVENTIONS” To get started with any new system, one must first understand the rules.

1) In the text a ● colored dot cautions you to make sure you use additional digit(s) to ensure greatest specificity.

2) ■ “Unspecified” The Square before a code indicates there are more specific codes without the symbol. It is still a valid first line code but if possible look for the code with highest specificity.

3) “OGCR” This symbol indicates there is “Official Guidelines for Coding and Reporting”. The passage is usually placed near the codes in a colored box.
ICD-10 Rules

4) “CC” Indicates complications and comorbidities. “MCC” indicates Major Complications and comorbidities. Published in the Federal register these two codes address Inpatient Prospective Payment System (IPPS).

5) Z codes that have a number 1 inside a circle before them means the code must be listed first.

6) The ½ symbol inside a circle before a Z code indicates this code may be the first or second listed code.

7) The number 2 inside a circle before Z codes means it is listed as a secondary code.
ICD-10 Rules

8) The “Excludes 1” is when two conditions can not occur together.

9) The “Excludes 2” means not included here. This is the case where it is acceptable to use both the code and the excluded code together.

10) The Code first/Use additional code means when there are multiple body system manifestations you code the underlying condition first and the manifestation second.

11) “In diseases classified elsewhere” these codes are never permitted to be used as first line codes. These codes must be listed after the underlying condition.
ICD-10 Rules

12) “Code also” means two codes may be required but the sequencing of the codes is discretionary.

13) “7th characters” means the applicable 7th character must always be used and “placeholder x” uses as a 5th character at certain 6 character codes to allow for future expansion.

14) “and” This word is interpreted as either “and” or “or”.

15) “Includes” in a colored box further defines or gives examples of the content. This notation appears immediately under a code title.
ICD-10 Rules

16) Abbreviations: “NEC” = “Not Elsewhere Classifiable” this is another specified code, used when a specific code is not available. “NOS” = “Not otherwise specified”, this indicates an unspecified code.
ICD-10 Coding for Chiropractic

Codes at their highest level of specificity are in bold type

↑ Highest Specificity Column (code from this column only)
Inclusion Notes

After the three level classification (top level) code, you may notice several additional diseases or conventions.

These are synonyms (additional or different names with equivalent meanings) for the term your are searching for.
Instructional Notes

Under the three letter top level entry for any code, you may find notes about what the code may and may not be used for.

These instructional notes are very important.
Instructional Notes

[ ] Brackets enclose words that are synonyms, alternative wordings, or explanatory phrases.

( ) Parentheses enclose supplementary words. The terms within parentheses are nonessential modifiers.

: Colons are used when the term is incomplete and requires one or more of the modifiers that follow to clarify its meaning.

X Placeholder x for codes less than six characters that will require a seventh character. Placeholders can also be assigned for characters in the fourth through sixth positions.
How do I find the ICD-10 code?

The General Equivalence Mappings (GEMs)
-created by the National Center for Health Statistics
-free FindACode app for Android and iOS
Three methods using the ChiroCode ICD-10 book:

1. GEMs code map (but don’t stop there!)
2. Alphabetic index (don’t stop here either!)
3. Commonly used code list (this is not safe either!)

All of these methods require you to end up in the tabular list. It is only there where you can find the right code.
How do I find the ICD-10 code?

One-to-one mapping:
723.1 Cervicalgia $\rightarrow$ M54.2 Cervicalgia

One-to-four mapping:
724.4 Thoracic or lumbosacral neuritis (radicular syndrome of the lower limbs) $\rightarrow$

M54.14, M54.15, M54.16, M54.17
Radiculopathy
How do I find the ICD-10 code?

One-to-many mapping:

733.82 Other disorders of bone and cartilage, nonunion of fracture →

S02.91XK through S92.919K
(A total of 2530 corresponding ICD-10-CM possibilities!!!)
How do I find the ICD-10 code?

Combination mapping:

724.3 *Sciatica* ➔
M54.30 *Sciatica, unspecified side* (M54.31 and M54.32 *right or left*)
OR
M54.40 *Sciatica with lumbago* (M54.41 and M54.42 *right or left*)
How do I find the ICD-10 code?

Combination mapping:

724.3 *Sciatica* ➔
M54.30 *Sciatica, unspecified side*
(M54.31 and M54.32 *right or left*)
OR
M54.40 *Sciatica with lumbago, unspecified*
(M54.41 and M54.42 *right or left*)
How do I find the ICD-10 code?

Look up 724.3 in the “Code Map” section (this is using GEMs-page 82)
-M54.30

Look up “sciatica” in the ICD-10 index (page 455)
-M54.3

Now find it in the tabular list (page 207)
-unspecificed codes need to be investigated
-at least five characters required to code to the highest level of specificity
How do I find the ICD-10 code?

One-to-two mapping:

728.85 *Spasm of muscle* ➔
M62.40 *Contracture of muscle, unspecified site*
M62.838 *Other muscle spasm*

But is that the whole story?
How do I find the ICD-10 code?

Look up these codes in the tabular list (page 215) and you’ll find:

728.85 Spasm of muscle

M62.40 Contracture Of Muscle Unspecified Site
M62.411 Contracture Of Muscle Right Shoulder
M62.412 Contracture Of Muscle Left Shoulder
M62.419 Contracture Of Muscle Unspecified Shoulder
M62.421 Contracture Of Muscle Right Upper Arm
M62.422 Contracture Of Muscle Left Upper Arm
M62.429 Contracture Of Muscle Unspecified Upper Arm
M62.431 Contracture Of Muscle Right Forearm
M62.432 Contracture Of Muscle Left Forearm
M62.439 Contracture Of Muscle Unspecified Forearm
M62.441 Contracture Of Muscle Right Hand
M62.442 Contracture Of Muscle Left Hand
M62.449 Contracture Of Muscle Unspecified Hand
M62.451 Contracture Of Muscle Right Thigh
M62.452 Contracture Of Muscle Left Thigh
M62.459 Contracture Of Muscle Unspecified Thigh
M62.461 Contracture Of Muscle Right Lower Leg
M62.462 Contracture Of Muscle Left Lower Leg
M62.469 Contracture Of Muscle Unspecified Leg
M62.471 Contracture Of Muscle Right Ankle And Foot
M62.472 Contracture Of Muscle Left Ankle And Foot
M62.479 Contracture Of Muscle Unspecified Ankle And Foot
M62.48 Contracture Of Muscle Other Site
M62.49 Contracture Of Muscle Multiple Sites

M62.831 Muscle Spasm Of Calf
M62.838 Other Muscle Spasm
General Coding Guidelines

1. Locating a code in the ICD-10-CM

To select a code in the classification that corresponds to a diagnosis or reason for visit documented in the chart. First locate the term in the alphabetical index, and then verify in tabular list. Read and be guided by the instructional notations that appear in both the Alphabetical Index and the Tabular List.
General Coding Guidelines

2. Level of Detail in Coding
Code the highest level of specificity

3. Acute and Chronic Conditions
If the same condition is described as both acute and chronic, and separate subentries exist in the Alphabetical Index at the same indentation level, code both and sequence the acute code first.

4. Sequela
A sequela is the residual effect after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela can be used.
General Coding Guidelines

5. Reporting Same Diagnosis Code More than Once

Each unique ICD-10-CM diagnosis code may be reported only once for an encounter.

6. Laterality

Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right, or bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the chart note, assign the code for the unspecified side.
Examples

ICD-10-CM EXTERNAL CAUSE CODES
Etiology

The causation of your patient’s symptoms

- Important for correct code selection in ICD-10
- Important for auto and worker’s compensation cases
- Important for Medicare
  - More Medicare carriers are labeling returning patient’s care as supportive.
  - Supportive care = Maintenance care = Non Covered Service
Have you ever wondered what the code for Heelies accident would be?

- V00.151_ Fall from Heelies
- V00.152_ Heelies colliding with stationary object
- V00.158_ Other Heelies accident
Examples
Examples
Examples
Examples
Example
Example
The Vertebral Subluxation Complex
The Vertebral Subluxation Complex

- Spinal Kinesiopathology
- Neuropathophysiology
- Myopathology
- Histopathology
- Pathophysiology
Spinal Kinesiopathology

The Abnormal Movement or Position of a Vertebra
# 739 Segmental Dysfunction

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>739.0</td>
<td>Head Region</td>
</tr>
<tr>
<td>739.1</td>
<td>Cervical Region</td>
</tr>
<tr>
<td>739.2</td>
<td>Thoracic Region</td>
</tr>
<tr>
<td>739.3</td>
<td>Lumbar Region</td>
</tr>
<tr>
<td>739.4</td>
<td>Sacral Region</td>
</tr>
<tr>
<td>739.5</td>
<td>Pelvic Region</td>
</tr>
<tr>
<td>739.6</td>
<td>Lower Extremities</td>
</tr>
<tr>
<td>739.7</td>
<td>Upper Extremities</td>
</tr>
<tr>
<td>739.8</td>
<td>Rib Cage</td>
</tr>
<tr>
<td></td>
<td>M99.00 Segmental and somatic dysfunction of head region</td>
</tr>
<tr>
<td></td>
<td>M99.01 Segmental and somatic dysfunction of cervical region</td>
</tr>
<tr>
<td></td>
<td>M99.02 Segmental and somatic dysfunction of thoracic region</td>
</tr>
<tr>
<td></td>
<td>M99.03 Segmental and somatic dysfunction of lumbar region</td>
</tr>
<tr>
<td></td>
<td>M99.04 Segmental and somatic dysfunction of sacral region</td>
</tr>
<tr>
<td></td>
<td>M99.05 Segmental and somatic dysfunction of pelvic region</td>
</tr>
<tr>
<td></td>
<td>M99.06 Segmental and somatic dysfunction of lower extremity</td>
</tr>
<tr>
<td></td>
<td>M99.07 Segmental and somatic dysfunction of upper extremity</td>
</tr>
<tr>
<td></td>
<td>M99.08 Segmental and somatic dysfunction of rib cage</td>
</tr>
</tbody>
</table>
# 839 Subluxation (Cervical Spine)

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>839.00 Cervical Vertebra, unspecified</td>
<td>S13.101_ Dislocation of unspecified cervical vertebra</td>
</tr>
<tr>
<td>839.01 First Cervical</td>
<td>S13.111_ Dislocation of C0/C1 cervical vertebra</td>
</tr>
<tr>
<td>839.02 Second Cervical</td>
<td>S13.121_ Dislocation of C1/C2 cervical vertebra</td>
</tr>
<tr>
<td>839.03 Third Cervical</td>
<td>S13.131_ Dislocation of C2/C3 cervical vertebra</td>
</tr>
<tr>
<td>839.04 Fourth Cervical</td>
<td>S13.141_ Dislocation of C3/C4 cervical vertebra</td>
</tr>
<tr>
<td>839.05 Fifth Cervical</td>
<td>S13.151_ Dislocation of C4/C5 cervical vertebra</td>
</tr>
<tr>
<td>839.06 Sixth Cervical</td>
<td>S13.161_ Dislocation of C5/C6 cervical vertebra</td>
</tr>
<tr>
<td>839.07 Seventh Cervical</td>
<td>S13.171_ Dislocation of C6/C7 cervical vertebra</td>
</tr>
<tr>
<td>839.08 Multiple Cervical</td>
<td>S13.181_ Dislocation of C7/T1 cervical vertebra</td>
</tr>
<tr>
<td></td>
<td>S13.101_ Dislocation of unspecified cervical vertebra</td>
</tr>
</tbody>
</table>
839 Subluxation (Thoracic Spine)

ICD-9
839.21 Thoracic Vertebra

ICD-10
S23.101_ Dislocation of unspecified thoracic vertebra
839 Subluxation (Lumbar Spine)

ICD-9

839.20 Lumbar Vertebra

ICD-10

S33.101_ Dislocation of unspecified lumbar vertebra
### 839 Subluxation (Pelvic & Sacrum)

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>839.42 Sacrum</td>
<td>S33.2xx_ Dislocation of sacroiliac &amp; sacrococcygeal joint</td>
</tr>
<tr>
<td>839.69 Other (pelvic)</td>
<td>S33.39x_ Dislocation of other parts of lumbar spine &amp; pelvis</td>
</tr>
</tbody>
</table>
Neuropathophysiology

Abnormal Function of the Neurological System
Neurological Diagnosis

ICD-9

723.4 Brachial Neuritis
724.3 Sciatica
724.4 Thoracic or lumbosacral neuritis or radiculitis
782.0 Disturbance of skin

ICD-10

M54.12 Radiculopathy, cervical region
M54.13 Radiculopathy, cervicothoracic region
M54.30 Sciatica, unspecified side
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M54.16 Radiculopathy, lumbar region
M54.17 Radiculopathy, lumbosacral region
Neurological Diagnosis

ICD-9

782.0 Disturbance of skin sensation

ICD-10

R20.0 Anesthesia of skin
R20.1 Hypoesthesia of skin
R20.2 Paresthesia of skin
R20.3 Hyperesthesia
R20.8 Other disturbances of skin sensation
R20.9 Unspecified disturbance of skin sensation
Myopathology

Pathological Changes Occurring in the Spinal Musculature
ICD-9

728.10 Muscular Calcification & Ossification
728.2 Muscular Wasting & Disuse Atrophy
728.85 Muscle Spasm
729.1 Myalgia
728.87 Muscle Weakness Generalized
738.2 Acquired Deformity Neck

ICD-10

M61.9 Calcification and ossification of muscle unspecified
M62.50 Muscle Wasting and atrophy, not elsewhere classified, unspecified site
M62.40 Contracture of muscle, unspecified site
M62.838 Other muscle spasm
M62.81 Muscle weakness (generalized)
M95.3 Acquired deformity of neck
Histopathology

Abnormal Soft Tissue Function
## Histopathology Diagnosis

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>722.0 Cervical Disc</td>
<td>M50.20 Other cervical disc displacement, unspecified cervical region</td>
</tr>
<tr>
<td>722.10 Lumbar Disc</td>
<td>M51.26 Other intervertebral disc displacement, lumbar region</td>
</tr>
<tr>
<td>722.11Thoracic Disc</td>
<td>M51.27 Other intervertebral disc displacement, lumbosacral region</td>
</tr>
<tr>
<td>724.8 Facet Syndrome</td>
<td>M51.24 Other intervertebral disc displacement, thoracic region</td>
</tr>
<tr>
<td></td>
<td>M51.25 Other intervertebral disc displacement, thoracolumbar region</td>
</tr>
<tr>
<td></td>
<td>M53.82 Other specified dorsopathies of cervical region (facet syndrome)</td>
</tr>
</tbody>
</table>
Pathophysiology

Abnormal Function of the Spine and Body
Pathophysiology Diagnosis

ICD-9

722.4 Degeneration of Cervical Disc
722.51 Degeneration Thoracic or thoracolumbar IVD
722.52 Degeneration of Lumbar IVD

ICD-10

M50.30 Other cervical disc degeneration, unspecified cervical region
M51.34 Other intervertebral disc degeneration, thorax region
M51.35 Other intervertebral disc degeneration, thoracolumbar region
M51.36 Other intervertebral disc degeneration, lumbar region
M51.37 Other intervertebral disc degeneration, lumbosacral region
Spondylosis

ICD-9

721.0 Cervical Spondylosis w/out myelopathy
721.2 Thoracic Spondylosis w/out myelopathy
721.3 Lumbosacral Spondylosis w/out myelopathy

ICD-10

M47.812 Spondylosis w/out myelopathy or radiculopathy, cervical region
M47.12 Other spondylosis w/myelopathy, cervical region
M47.814 Spondylosis w/out myelopathy or radiculopathy, thoracic region
M47.817 Spondylosis w/out myelopathy or radiculopathy, lumbosacral region
How do I code for a subluxation?

**Fifth character gives the specific vertebral level:**

S13.10  Subluxation and dislocation of unspecified cervical vertebrae
S13.11  Subluxation and dislocation of C0/C1 cervical vertebrae
S13.12  Subluxation and dislocation of C1/C2 cervical vertebrae
S13.13  Subluxation and dislocation of C2/C3 cervical vertebrae
S13.14  Subluxation and dislocation of C3/C4 cervical vertebrae
S13.15  Subluxation and dislocation of C4/C5 cervical vertebrae
S13.16  Subluxation and dislocation of C5/C6 cervical vertebrae
S13.17  Subluxation and dislocation of C6/C7 cervical vertebrae
S13.18  Subluxation and dislocation of C7/T1 cervical vertebrae
Sixth character differentiates between a subluxation and a dislocation:

0 = subluxation  1 = dislocation

S13.110_ Subluxation of C0/C1 cervical vertebrae
S13.111_ Dislocation of C0/C1 cervical vertebrae
What is _?

Add the appropriate 7th character to each code from category

A- initial encounter
D- subsequent encounter
S- sequela

Example: S13.101A Dislocation of Cervical Vertebrae initial encounter
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S13.100</td>
<td>Subluxation of unspecified cervical vertebrae</td>
<td>S13.101</td>
<td>Dislocation of unspecified cervical vertebrae</td>
</tr>
<tr>
<td>A-initial encounter</td>
<td></td>
<td>A-initial encounter</td>
<td></td>
</tr>
<tr>
<td>D-subsequent encounter</td>
<td></td>
<td>D-subsequent encounter</td>
<td></td>
</tr>
<tr>
<td>S-sequela</td>
<td></td>
<td>S-sequela</td>
<td></td>
</tr>
</tbody>
</table>
What to Code First?

Subluxation (etiology)

Condition (manifestation)

Severe diagnosis
  ◦ Neurological
  ◦ Structural
  ◦ Functional
  ◦ Soft Tissue
  ◦ Pain
Payers will decide

Ultimately it will be up to the payers to decide if it is a subluxation, dislocation, or if they want the most severe diagnosis.
Chapter 13

Diseases of the Musculoskeletal System & Connective Tissue
Introduction

Site for many conditions is more specific

Laterality

Condition acute or chronic

Episode of Care
  ◦ Initial
  ◦ Subsequent
  ◦ Sequela
Acute Traumatic vs. Chronic Conditions

Healed Injury- Bone, joint or muscle conditions that are a result of a healed injury Chapter 13

Recurrent or chronic conditions will also be found in Chapter 13

Acute injury- Current, acute injuries with known mechanism of injury can be found in Chapter 19
Osteoarthritis

ICD-10 has multiple codes in multiple categories for osteoarthritis. (M15, M16, M17, M18, and M19)

Specific codes for primary and secondary OA

Laterality comes into play for many of these codes
Sixty one year old female presents to your office with ongoing right hip pain and stiffness. Patient stated she had a soft-tissue injury to her right hip six years ago following a bicycle accident. X-rays at the time negative for fracture.

Tenderness to palpation in the right hip, with a positive Patrick’s test on the right reproducing the hip symptoms. X-rays of the left hip were unremarkable, however, the right hip showed sclerosis of the superior aspect of the acetabulum.

DX: Post-traumatic osteoarthritis of the right hip.

ICD-10: 1. M99.06 Segmental and somatic dysfunction of lower extremity
2. M16.51 Unilateral post-traumatic osteoarthritis, right hip
Spondylosis

Spondylosis is stiffening or fixation of the vertebral joint with fibrous or bony union across the joint resulting from a disease process and affecting the vertebrae, intervertebral disc and soft tissue of the spine.
Spondylosis symptoms

Radiculopathy
Facet mediated pain
Myelopathy
Spinal Artery Compromise
Spondylosis Documentation Requirements

Identify condition:

- Anterior Spinal Artery compression
- Spondylosis with myelopathy
- Spondylosis without myelopathy
- Spondylosis with radiculopathy
- Unspecified
Spondylosis Documentation Requirements

Identify site:

- Occipito-atlanto-axial
- Cervical region
- Cervicothoracic region
- Thoracic region
- Thoracolumbar region
- Lumbar region
- Lumbosacral region
- Sacral/sacroccocygeal region
- Unspecified
### ICD-10-CM Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M47.016</td>
<td>Anterior spinal artery compression syndromes, lumbar region</td>
</tr>
<tr>
<td>M47.26</td>
<td>Other spondylosis with radiculopathy, lumbar region</td>
</tr>
<tr>
<td>M47.27</td>
<td>Other spondylosis with radiculopathy, lumbosacral region</td>
</tr>
<tr>
<td>M47.28</td>
<td>Other spondylosis with radiculopathy, sacral and sacroccocygeal region</td>
</tr>
<tr>
<td>M47.816</td>
<td>Spondylosis without myelopathy or radiculopathy, lumbar region</td>
</tr>
<tr>
<td>M47.817</td>
<td>Spondylosis without myelopathy or radiculopathy, lumbosacral region</td>
</tr>
</tbody>
</table>
**Intervertebral Disc Disorders (IVD)**

IVD conditions include displacements without myelopathy, Schmorl’s nodes, degeneration of IVD, disc displacement with myelopathy, and other unspecified disc disorders.
ICD-10 Categories

M50 contains codes for cervical disc

M51 contains codes for thoracic and thoracolumbar, lumbar, and lumbosacral disc

Documentation must clearly state the specific condition and any associated myelopathy or radiculopathy.
ICD-10-CM

CASE FILE EXAMPLES
Thirty-three year old female presents to ABC chiropractic for right arm pain and weakness, with a secondary complaint of neck pain. There is no history of trauma, and she states it started insidiously two weeks ago when she woke up with sharp pain radiating down into her right arm and neck stabbing pain. Since then the pain has subsided somewhat, but is now described as numbness with weakness in the right arm.

Examination revealed decreased range of motion on all planes, with pain noticeable on right rotation, right lateral flexion, and extension. These movements cause moderate sharp and stabbing pains in the right cervical spine with radiation into the right upper extremity.

Muscle testing is 4/5 in the right middle deltoid and biceps.

Sensory testing elicited hypoesthesia in the right C5/C6 dermatomes

DTR 1+ right bicep and 2+ on the left.
Example cont.

Palpation reveals spinal fixations at C5/C6 with tenderness and spasms in the cervical paraspinals, upper trapezius on the right.

Radiographs reveal decrease disc space at the C5/C6 spinal areas.

MRI shows a disc displacement right posterior lateral protrusion at C5/C6
# ICD-10 Diagnosis

<table>
<thead>
<tr>
<th></th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M99.01</td>
<td>Segmental and somatic dysfunction of cervical region</td>
</tr>
<tr>
<td>2</td>
<td>M50.12</td>
<td>Cervical disc disorder with radiculopathy, mid-cervical region</td>
</tr>
<tr>
<td>3</td>
<td>M62.83</td>
<td>Muscle spasm of back</td>
</tr>
<tr>
<td>4</td>
<td>M54.2</td>
<td>Cervicalgia</td>
</tr>
</tbody>
</table>
CAUSATION DETAILS:

This onset of the primary complaint started as follows:
The patient presents today with a chief complaint of neck pain and a secondary complaint of headaches.

He stated that while playing Sunday he was struck helmet to helmet by a very large defensive lineman. He felt immediate pain and was somewhat disoriented until he got to the sidelines. He also began to experience dizziness and mild nausea, but did not vomit. Since the game he has had constant neck pain and headaches.
SUBJECTIVE:

The patient indicated today that he is experiencing constant moderate pain in the area of the cervical spine. This is restricted movement as well as stiffness, sore and tight pain neck. He finds that nothing makes his neck pain feel better and seems to be aggravated by repetitious movements, turning the head left and turning the head right.

He also reports he is experiencing constant moderate headache pain. He further describes it as throbbing and pounding pain generalized in the top of the head. Mr. Stafford related that resting gives him relief but finds that lights and fatigue causes more distress.

Mr. Stafford reported his neck pain at 6 and headache at 5, based on a 1 to 10 pain scale.
REVIEW OF SYSTEMS:
General: Denies fever, chills, fatigue, and no major weight loss or gain.
Psych: DISTURBED SLEEP
Eyes: DOUBLE VISION
GI: NAUSEA

Past Medical Health: Denies past medical history

FAMILY HISTORY:
The patient has no family history of problems.
SOCIAL HISTORY
A social history was obtained from Mr. Mathew Stafford. Mr. Stafford's social history was reviewed and was found to be consistent with previous findings.
**NECK DISABILITY ASSESSMENTS:**
The Neck Pain and Disability Index was used to indicate Mr. Stafford's perceived pain and disability. It is a valid indicator since the patient rated himself, thus avoiding interviewer interference. The patient related his capability in the activities of daily living as follows:

- **Pain Intensity:** "The pain is moderate at the moment."
- **Personal Care:** "It is painful to look after myself and I am slow and careful."
- **Lifting:** "Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table)."
- **Reading:** "I can read as much as I want with moderate pain in my neck."
- **Headaches:** "I have moderate headaches which come frequently."
- **Concentration:** "I have a fair degree of difficulty in concentrating when I want to."
- **Work:** "I cannot do my usual work."
- **Driving:** "I can drive my car as long as I want with moderate pain in my neck."
- **Sleeping:** "My sleep is moderately disturbed (2-3 hours sleepless)."
- **Recreation:** "I can hardly do any recreational activities because of pain in my neck."

The patient's neck disability index on 10/17/2013 was 50. The patient's score fell into the 40 - 60% range indicates severe disability.
GENERAL APPEARANCE:
This patient is a poorly-appearing 25 year old male in a moderate amount of distress. The patient was awake, alert and oriented and in moderate pain. Mathew showed good eye contact. The patient appeared comfortable and moderately depressed. The patient showed normal grooming and appropriate dress.

VITAL SIGNS:
Pulse Rate 72  
Sitting Pressure/Systolic L:120  
Sitting Pressure/Diastolic L:80  
Height 6'3"  
Weight 232  
Body Mass Index 28.99

POSTURAL ANALYSIS:
Postural Analysis was evaluated on Mr. Stafford and the following was noted. This patient's posture while standing was generally fair. His posture while sitting seemed to be fair.
**RANGE OF MOTION:**

Spinal ROM: Range of motion actively and passively performed was visually assessed and revealed decreased movement and pain on all planes of motion.

<table>
<thead>
<tr>
<th>Cervical:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexion</td>
<td>Decreased</td>
</tr>
<tr>
<td>Extension</td>
<td>Decreased</td>
</tr>
<tr>
<td>Right Lateral Flexion</td>
<td>Decreased</td>
</tr>
<tr>
<td>Left Lateral Flexion</td>
<td>Decreased</td>
</tr>
<tr>
<td>Right Rotation</td>
<td>Decreased</td>
</tr>
<tr>
<td>Left Rotation</td>
<td>Decreased</td>
</tr>
</tbody>
</table>
ORTHO/NEURO:

Romberg Sign was absent. The patient was instructed to stand with their feet together and arm at their sides. The examiner stood close enough to catch the patient should they fall. Since the patient was able to do that pretty well, they were then instructed to close their eyes. The sign was absent due to the patient being able to retain their balance with minimal swaying.

Finger to Nose Test was positive bilaterally. While standing with their arms extended, the patient was instructed to touch their nose with one hand, then with the other, and then with both. The patient was then instructed to do this with their eyes closed. The test was positive since they were not able to do it either with eyes open, or with eyes closed, or both.

Maximum Cervical Compression Test was negative for a radicular component, but elicited localized neck pain. While seated, the patient laterally flexed their head and brought the chin of the involved side to the shoulder.

Jackson Compression Test was negative, but did reveal localized cervical spine pain. With the examiner behind the seated patient, the patient laterally flexed the head while the examiner clasped hands over the patient's head and pushed down.

Distraction Test was positive. The examiner placed the open palm of one hand under the patient's chin, and the other hand on the patient's occiput. Then, the patient's head was lifted to remove weight from the neck. The movement lessened the patient's degree of pain.
DEEP TENDON REFLEXES:

Biceps Reflex bilaterally was 2+/5.
Brachioradialis Reflex bilaterally was 2+/5.

CRANIAL NERVES:

Cranial nerve examination was performed on CN I - XII and no abnormalities were detected.

MUSCLE TESTING:

<table>
<thead>
<tr>
<th>Muscle</th>
<th>Right - 5/5</th>
<th>Left - 5/5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deltoid (C5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biceps (C5, C6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist Extensors (C6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist Flexors (C7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finger Flexors (C8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finger Interossei (C8-T1)</td>
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</tr>
</tbody>
</table>

DERMATOMES:

Evaluation of the dermatomes utilizing a pin wheel revealed all dermatomes tested were normal.
OBJECTIVE:

Spinal evaluation revealed severe joint restriction at C1, C2 and C5 - C7. On palpation of the spinal segments there was a strong pain level at C1, C2 and C5 - C7 bilaterally. Palpation revealed severe spasticity of the suboccipital muscles and cervical paraspinal muscles bilaterally.
ICD-9 DIAGNOSIS:

839.08  Closed Dislocation, Multiple Cervical Vertebrae
850.0  Concussion with No Loss of Consciousness
723.8  Other Syndromes affecting Cervical Region
728.85  Spasm of Muscle
723.1  Cervical Spine Pain
784.0  Headache
# ICD-10 Diagnosis

1. **S13.101A** Dislocation of Cervical Vertebrae initial encounter  
2. **S06.0x0A** Concussion w/out loss of consciousness initial encounter  
3. **M53.82** Other specified dorsopathies of cervical region (facet syndrome)  
4. **M62.838** Other muscle spasms  
5. **M54.2** Cervicalgia  
6. **R51** Headache  
7. **W21.81A** Striking against or struck by football helmet
Examination

GENERAL APPEARANCE:
The general appearance of Ms. Doe is normal.

VITAL SIGNS:

Pulse Rate 71
Sitting Pressure/Systolic L:106
Sitting Pressure/Diastolic L:67
Height 5'4"
Weight 145
Body Mass Index 24.89
Case 1

Fifty-eight year old male presents to ABC chiropractic for an initial visit. Patient is a long distance truck driver of 25 years. He complains of lower back pain and right leg paresthesia while sitting after he gets home from driving an 8 hour day.

Vital Signs—normal
Gait--normal
Lumbar ROM was restricted on all planes with pain more noticeable on extension and right lateral flexion. The RLF reproduced the pain radiating into his right leg. Dermatome testing was positive for hypoesthesia in the L4 dermatome on the right. Left was negative. Kemp’s test was positive on the right and negative on the left. Radiographs revealed spondylosis in the lumbar spine.

*ICD-10- Diagnosis*  *M47.26 Other spondylosis with radiculopathy, lumbar region*
History

CAUSATION DETAILS:

The patient presents with full spine complaints of a gradual onset. She currently works as a bank teller and must stand on her feet for 4 to 6 hours at a time. The pain is worse at the end of the day.

SUBJECTIVE:

On today’s appointment, Ms. Doe reported that she is feeling frequent moderate pain in the lower back. This is throbbing pain lower back. Additionally, she states that she has been feeling constant moderate pain in the upper back area. This is further described as throbbing pain. Ms. Doe stated that nothing makes her more comfortable but her upper back pain is a lot more uncomfortable due to exercising and repetitious movements.

This patient also reported that she has been feeling frequent moderate pain in the neck area. She further describes it as sore and stiffness pain neck. Repetitious movements, turning the head left and turning the head right causes the neck pain to be aggravated while nothing makes it better.

Ms. Doe was asked to determine her opinion of her current condition status. Based on a 1 to 10 pain scale, Ms. Doe estimated her low back pain at 5 and upper back pain at 5 and neck pain at 4.
ROS, PMSH, Family History

REVIEW OF SYSTEMS:

GU: Denies polyuria, nocturia, incontinence, or hematuria

GI: Denies nausea, vomiting, diarrhea, constipation, incontinence.

Medical Health: *Is significant for rollover motor vehicle accident in 2011 in which she injured her neck, upper back and lower back. She stated her car hit black ice and rolled and hit a tree.*

DRUGS: No medications

FAMILY HISTORY:

The patient has no family history of problems.

SOCIAL HISTORY

A review of Ms. Kimberly Doe’s social history was obtained. Ms. Doe's social history was reviewed and was found to be consistent with previous findings.
Examination

GENERAL APPEARANCE:

The general appearance of Ms. Doe is normal.

VITAL SIGNS:

Pulse Rate 71
Sitting Pressure/Systolic L:106
Sitting Pressure/Diastolic L:67
Height 5'4"
Weight 145
Body Mass Index 24.89
Range of Motion

RANGE OF MOTION: Range of motion was visually performed both actively and passively, and elicited pain on extension and rotation in the cervical and lumbar spines.

Cervical:

<table>
<thead>
<tr>
<th>Flexion</th>
<th>Decreased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extension</td>
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</tr>
<tr>
<td>Right Lateral Flexion</td>
<td>Decreased</td>
</tr>
<tr>
<td>Left Lateral Flexion</td>
<td>Decreased</td>
</tr>
<tr>
<td>Right Rotation</td>
<td>Decreased</td>
</tr>
<tr>
<td>Left Rotation</td>
<td>Decreased</td>
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</tbody>
</table>
Lumbar ROM

<table>
<thead>
<tr>
<th>Lumbar:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Flexion</td>
<td>Decreased</td>
</tr>
<tr>
<td>Extension</td>
<td>Decreased</td>
</tr>
<tr>
<td>Right lateral flexion</td>
<td>Decreased</td>
</tr>
<tr>
<td>Left Lateral Flexion</td>
<td>Decreased</td>
</tr>
</tbody>
</table>
Ortho/Neuro Testing

Maximum Cervical Compression Test was **negative bilaterally for radiating pain into the upper extremities**, but did **elicit pain in the C5-C7 facet joints bilaterally**. While seated, the patient laterally flexed their head and brought the chin of the involved side to the shoulder. This motion caused no radiating pain on the side of lateral flexion and rotation. The same result was obtained when the other side was tested.

Jackson Compression Test was **negative bilaterally for radiating pain into the upper extremities**, but did **elicit pain in the C5-C7 facet joints bilaterally**. With the examiner behind the seated patient, the patient laterally flexed the head while the examiner clasped hands over the patient's head and pushed down. This maneuver did not significantly increase the patient's amount of pain.

Kemp's Test was negative bilaterally. The examiner stood behind the patient and anchored the pelvis and sacrum with one hand while grasping the opposite shoulder with the other hand. The shoulder was then forced obliquely back, down, and medial.

Bechterew Sitting Test was negative bilaterally. With the patient seated and legs dangling over the edge of the table, the examiner instructed the patient to extend one knee straight out then repeat with the other knee. Then, the patient repeated the maneuver with both knees. The patient was able to do this without any pain and without leaning backwards.
Ortho/Neuro Testing

Ely Heel To Buttock Test was positive on the left, negative on the right. This two stage test was performed with the patient lying prone. The examiner flexed the patient’s knee approximating the heel to the opposite buttock. From this position, the examiner hyperextended the patient's thigh. The test was positive if the patient was unable to do the test, unable to extend the thigh, if femoral radicular pain was produced, and/or if upper lumbar discomfort was present. The test was negative on the right as the patient was able to perform this test without any difficulty.

Nachlas Test was positive on the left, negative on the right. The examiner stood on the side of the patient ipsilateral to the pain while the patient lay prone. With one hand, the examiner raised the foot of the involved side and maximally flexed the knee. With the other hand, the examiner pushed downward on the patient's pelvis. The patient experienced pain in the joint. When the right side was tested, there was no pain elicited.

Patrick’s Test was negative bilaterally. With the patient supine, the examiner placed the foot of the patient's involved side on the opposite knee. This made the hip joint flexed, abducted, and externally rotated. In this position, the patient did not experience any significant pain. The same result was obtained on the other side.
Neurological Testing

Biceps Reflex bilaterally was 2+/5.

Brachioradialis Reflex bilaterally was 2+/5.

Triceps Reflex bilaterally was 2+/5.

Patella Reflex bilaterally was 2+/5.

Achilles Reflex done bilaterally was a 2+/5.

All dermatomes were normal

Muscle testing of the upper and lower extremity were bilaterally 5/5
Spinal Palpation

OBJECTIVE:

Palpation revealed a moderate degree of fixation at C5 - C7, T1 - T4, T10, T11, L4, L5 and the left/right ilium - sacrum. There is evidence elicited on palpation of a moderate degree of pain at C5 - C7, T1 - T4, T10, T11, L4, L5 and the ilium - sacrum bilaterally. Palpation revealed moderate tension of the cervical paraspinal muscles, upper thoracic muscles, lower thoracic muscles, lumbar paraspinal muscles and gluteal muscles bilaterally.

Additionally there was focal pain upon palpation at C5-C7 spinous processes, and T1-T4 spinous processes. There was also moderate to severe tenderness at the left L4 and L5 spinous processes.
ICD-9 Diagnosis

DIAGNOSIS:

- 739.3 Segmental Dysfunction, Lumbosacral Region
- 739.5 Nonallopathic Lesions of Pelvic Region, not elsewhere classified
- 739.4 Nonallopathic Lesions of Sacral Region, not elsewhere classified
- 720.1 Spinal Enthesopathy
- 724.2 Lumbar Spine Pain
- 739.2 Segmental Dysfunction, Thoracic Region
- 729.1 Myofascitis
- 724.1 Pain in Thoracic Spine
- 739.1 Segmental Dysfunction, Cervical Region
- 724.8 Cervical Facet Syndrome
- 723.1 Cervicalgia
### Lets Compare

**ICD-9**

**DIAGNOSIS:**

- 739.3 Segmental Dysfunction, Lumbosacral Region
- 739.5 Nonallopathic Lesions of Pelvic Region, not elsewhere classified
- 739.4 Nonallopathic Lesions of Sacral Region, not elsewhere classified
- 720.1 Spinal Enthesopathy
- 724.2 Lumbar Spine Pain
- 739.2 Segmental Dysfunction, Thoracic Region
- 729.1 Myofascitis
- 724.1 Pain in Thoracic Spine
- 739.1 Segmental Dysfunction, Cervical Region
- 724.8 Cervical Facet Syndrome
- 723.1 Cervicalgia

**ICD-10**

- M99.03 Segmental and somatic dysfunction of lumbar region
- M99.05 Segmental and somatic dysfunction of pelvic region
- M99.04 Segmental and somatic dysfunction of sacral region
- M46.06 Spinal Enthesopathy, lumbar region
- M54.5 Low Back Pain
- M99.02 Segmental and somatic dysfunction of thoracic region
- M79.1 Myalgia
- M54.6 Pain in Thoracic Spine
- M99.01 Segmental and somatic dysfunction of cervical region
- M53.82 Other specified dorsopathies of cervical region
- M54.2 Cervicalgia
Etiology Last Diagnosis

V47.02xS Driver of other type of car injured in collision with fixed or stationary object in nontraffic accident
Coding Practice
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What Areas of My Practice Will be Affected?

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

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

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

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

- Billing
  - New Code Set
  - Significant training
  - New reimbursement policies means new follow up, potential for increased denials, etc.
- Other?
What Should Practices do to Prepare?

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

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

• Learn the basics-review these notes again with your whole office

• Consider *ChiroCode Complete and Easy ICD-10 Coding for Chiropractic* or some other comprehensive resource

• Dedicate a few minutes of each office meeting to ICD-10

  1. Assign someone to read ten pages from the book, then report on what they learned (only 50 intro pages).
  2. Find articles in Chiropractic trade journals and share them at each meeting.
  3. Take a completed case and crosswalk it to ICD-10, then rework the documentation.
How do I implement ICD-10 in my practice?

**ChiroCode.com**: free email alerts, more training

**Medicare**: free training
- [www.cms.gov/Medicare/Coding/ICD10/CMS_ICD-10_Industry_Email_Updates.html](http://www.cms.gov/Medicare/Coding/ICD10/CMS_ICD-10_Industry_Email_Updates.html)

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

**ICD10Monitor.com**: free articles
For more information

Advanced Compliance Technologies
www.arkfeldcompliance.com
989-448-8065

The National Academy of Chiropractic Coders
www.correctcodingpays.com

tarkfeld@arkfeldcompliance.com