Diseases of the Nervous System (G00-G99)

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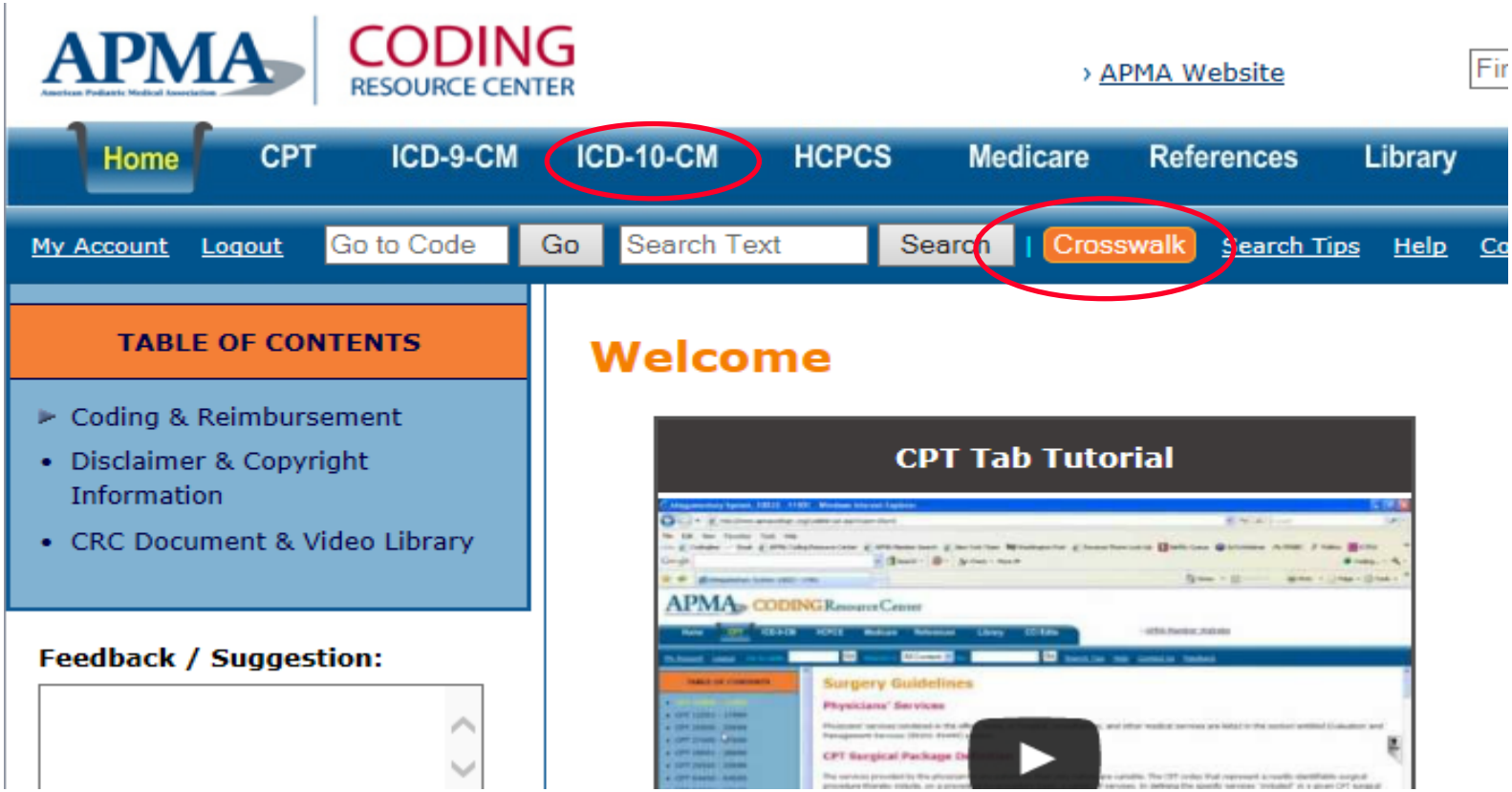

ICD-10 Official Guidelines for Coding & Reporting

Chapter 6 – Nervous System Coding Guidelines

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ICD-10 Tabular List of Diseases & Injuries

Volume 1 - Chapters

- Chapters are found exclusively in the Tabular List of Diseases and Injuries (Volume I of ICD-10-CM).
- There are 21 chapters, each representing condition-specific organ or system-based coding.

ICD-10-CM Guidelines

- Guidelines for the ICD-10 Tabular List of Diseases and Injuries are organized in sections.

Chapter 6: Diseases of the Nervous System

G00 – G09	Inflammatory diseases of the central nervous system
G10 – G14	Systemic atrophies primarily affecting the central nervous system
G20 – G26	Extrapyramidal and movement disorders
G30 – G32	Other degenerative diseases of the nervous system

Chapter 6: Diseases of the Nervous System

G35 – G37	Demyelinating diseases of the central nervous system
G40 – G47	Episodic and paroxysmal disorders
G50 – G59	Nerve, nerve root and plexus disorders
G60 – G65	Polyneuropathies and other disorders of the peripheral nervous system

Chapter 6: Diseases of the Nervous System

G70 – G73	Diseases of myoneural junction and muscle
G80 – G83	Cerebral palsy and other paralytic syndromes
G89 – G99	Other disorders of the nervous system

Chapter 6 – Diseases of the Nervous System (G00-G99)

- **Dominant/non-dominant side**
  - Codes from category G81, Hemiplegia and hemiparesis, and subcategories, G83.1, Monoplegia of lower limb, G83.2, Monoplegia of upper limb, and G83.3, Monoplegia of lower limb, unspecified, identify whether the dominant or non-dominant side is affected
  - Should the affected side be documented, but not specified as dominant or non-dominant, and the classification system does not indicate a default, code selection is as follows:

Chapter 6 – Diseases of the Nervous System (G00-G99)

- For ambidextrous patients, the default should be dominant
  - If the left side is affected, the default is non-dominant
  - If the right side is affected, the default is dominant

Chapter 6 – Diseases of the Nervous System (G00-G99)

- **Pain – Category G89**
  - General coding information: Codes in category G89, pain not elsewhere classified, may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain and neoplasm related pain, unless otherwise indicated below:

If the pain is not specified as acute or chronic, post-procedural, or neoplasm-related, do not assign codes from category 89.

Chapter 6 – Diseases of the Nervous System (G00-G99)

- A code from category G89 should not be assigned if the underlying diagnosis is known, unless the reason for the encounter is pain control/management and not management of the underlying condition.
- When an encounter is for a procedure aimed at treating the underlying condition, a code for the underlying condition should be assigned as the principal diagnosis and no code from category G89 should be assigned.

Chapter 6 – Diseases of the Nervous System (G00-G99)

- Category G89 Codes as Principal or First-Listed Diagnosis
  - Category G89 codes are acceptable as principal diagnosis or the first-listed code:
    - When pain control or pain management is the reason for the encounter. The underlying cause of the pain should be reported as an additional diagnosis, if known.

Chapter 6 – Diseases of the Nervous System (G00-G99)

- When a patient is admitted for the insertion of a neurostimulator for pain control, assign the appropriate pain code as the principal or first-listed diagnosis.
- When an encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same encounter, a code for the underlying condition should be assigned as the principal diagnosis and the appropriate pain code should be assigned as a secondary diagnosis.

Chapter 6 – Diseases of the Nervous System (G00-G99)

- **Use of Category G89 Codes in Conjunction with Site Specific Pain Codes**
  - Assigning category G89 Codes in Conjunction with Site Specific pain Codes:
    - Codes from category G89 may be used in conjunction with codes to identify the site of pain (including codes from Chapter 18) if the category G89 code provides additional information. If the code describes the site of the pain, but does not fully describe whether the pain is acute or chronic, then both codes be assigned.

Chapter 6 – Diseases of the Nervous System (G00-G99)

- **Sequencing of category G89 Codes with Site-Specific Pain Codes**
  - If the encounter is for pain control or pain management, assign the code from category G89 followed by the code identifying the specific site of pain.
  - If the encounter is for any other reason except pain control or pain management, and a related definitive diagnosis has not been confirmed by the provider, assign the code for the specific site of pain, followed by the appropriate code from category G89.

Chapter 6 – Diseases of the Nervous System (G00-G99)

- **Pain Due to Devices, Implants and Grafts**
  - See section I.C. 19, pain due to medical devices

Chapter 6 – Diseases of the Nervous System (G00-G99)

- **Postoperative Pain**
  - The provider's documentation should be used to guide the coding of postoperative pain, as well as Section III reporting Additional Diagnoses and Section IV Diagnostic Coding and Reporting in the Outpatient Setting
  - The default for post-operative pain not specified as acute or chronic is the code for the acute form
  - Routine or expected post-operative pain immediately after surgery should not be coded

Chapter 6 – Diseases of the Nervous System (G00-G99)

- Postoperative pain not associated with a specific postoperative complication is assigned to the appropriate postoperative pain code in category G89.
- Postoperative pain associated with a specific postoperative complication is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. If appropriate, use additional code(s) from category G89 to identify acute or chronic pain (G89.18 or G89.28).

Chapter 6 – Diseases of the Nervous System (G00-G99)

- **Chronic Pain**
  - Chronic pain is classified to subcategory G89.2
  - There is no time frame defining when pain becomes chronic pain.
  - The provider's documentation should be used to guide use of these codes.

Chapter 6 – Diseases of the Nervous System (G00-G99)

- **Neoplasm related Pain**
  - Code G89.3 is assigned to pain being documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic.
  - This code may be assigned as the principal or first-listed code when the stated reason for the encounter is documented as pain control/pain management. The underlying neoplasm should be reported as an additional diagnosis.

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- When the reason for the encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code G89.3 may be assigned as an additional diagnosis. It is not necessary to assign an additional code for the site of the pain.
  - See Section I.C.2 for instructions on the sequencing of neoplasms for all other stated reasons for the encounter (except for pain control/pain management).

Chapter 6 – Diseases of the Nervous System (G00-G99)

- **Chronic Pain Syndrome**
  - Central pain syndrome (G89.0) and chronic pain syndrome (G89.4) are different than the term “chronic pain,” and therefore codes should only be used when the provider has specifically documented this condition.

Chapter 6 – Diseases of the Nervous System (G00-G99)

G57.61	Lesion of plantar nerve, right lower limb
G57.62	Lesion of plantar nerve, left lower limb
G60.0	Charcot – Marie – Tooth Disease

Neuroma Example:

G57.61 (Lesion of plantar nerve, right lower limb)

G57.62 (Lesion of plantar nerve, left lower limb)

G57.61, G57.62 Initial Exam

- **Chief complaint:** "I have painful feet and numb toes."
- **Consultation:** Referring physician: Dr. XXXXXX
- **History of present illness:**

  Duration- 6-8 months

  Onset – insidious

  Location – 3rd interspace of both feet; 3rd and 4th toes of both feet

  Nature – aching and burning in 3rd interspace of both feet; 3rd and 4th toes of both feet are numb

  Precipitating factors – symptoms increases with weight bearing and ambulation, as well as with shoe pressure

  Previous treatment – went to the VA and saw a DPM; X-rays taken and received 2 pair of inserts

G57.61, G57.62 Initial Exam

Physical Findings:

- **General appearance**: well nourished, 38 year old male, alert, oriented to time, place, and person

- **Vital signs**:

  height: 6’0” tall

  weight: 205 lbs.

  BP: 122/82

  Pulse: 76/minute

G57.61, G57.62 Initial Exam

- **Cardiovascular**:
  - Arterial pulses: Dorsalis pedis and Posterior tibial pulses are +2/+4, bilaterally; balance of vascular exam unremarkable
  - Edema: no evidence of edema or varicosities
- **Musculoskeletal system:**
  - The patient's gait is tentative and guarded, bilaterally. There is pain upon palpation within the 3rd interspace of both feet. A positive Mulder's Sign is elicited with palpation, bilaterally within the 3rd interspace. The range of motion of both feet and ankles was unremarkable with no evidence of pain, crepitation, or contracture.

G57.61, G57.62 Initial Exam

- **Musculoskeletal system (continued):** Both lower extremities were stable, with no signs of dislocation, subluxation, or laxity. Muscle strength and tone were unremarkable, bilaterally.
- **Integumentary:** Inspection and palpation of the skin is unremarkable, bilaterally.
- **Neurological:**

  Sensation: Using a pin, the 3rd and 4th toes of both feet exhibited parasthesias. Otherwise the examination for sensation was unremarkable, bilaterally.

  Motor: Lower extremities were otherwise normal.

  Gait and stance: No limping was observed.

  Reflexes: Left ankle reflex was +2/+4. Right ankle reflex was +2/+4.

G57.61, G57.62 Initial Exam

- **Radiological examination:** 3 X-rays views of both feet were taken in the weight bearing position. Toes 2-5 of both feet are contracted, with varus rotation of toes 4 and 5, bilaterally. Mild hallux valgus is present, bilaterally. The 2nd and 3rd metatarsals on both feet are juxtaposed. A tailor's bunion is apparent on both feet. A small, inferior calcaneal exostosis is present, bilaterally.

- **Assessment:** Morton's neuroma, 3rd interspace, bilaterally

G57.61, G57.62 Initial Exam

- **Plan:** I discussed with the patient that it appeared that he had a neuroma in the 3rd interspace of both feet. I explained to the patient what a neuroma was and what was the etiology. I explained that the last mode of treatment was surgical intervention, either a decompression of the intermetatarsal ligament or excision of the neuroma. Initially a regimen of conservative care will be utilized.

G57.61, G57.62 Initial Exam

- **Plan (continued):** First, a series of anti-inflammatory injections utilizing ultrasound guidance. If not successful, a sclerosing injection will be administered. To supplement the anti-inflammatory injections, orthotics will be utilized. If the conservative regimen is exhausted without relief of the symptomatology, then surgical intervention will be explored which was briefly discussed today.
- **Procedure:** Injection of the 3rd interspace of both feet (1% lidocaine (plain), 0.25% Marcaine(plain), 1cc of Kenalog-10 (10 mg)

G57.61, G57.62 Initial Exam

ICD-9	ICD-10
355.6 Morton's neuroma	G57.61 Lesion of plantar nerve, right lower limb
	G57.62 Lesion of plantar nerve, left lower limb
781.2 Abnormality of gait	R26.2 Difficulty with walking, not elsewhere classified

G57.61, G57.62 Subsequent Exam

- **Chief complaint:** " My feet are more painful and my toes are still numb."
- **Course**- symptoms increase with weight bearing and ambulation, as well as with shoe pressure; became worse since the injection
- **Previous treatment**- went to the VA and saw a DPM: X-rays taken and received 2 pair of inserts
- Received steroid injections 2 weeks ago

G57.61, G57.62 Subsequent Exam

Physical findings:

- **Musculoskeletal system**: The patient's gait is tentative and guarded, bilaterally.
- There is pain upon palpation within the 3rd interspace of both feet. A positive Mulder's Sign is elicited with palpation, bilaterally within the 3rd interspace.
- The range of motion within both feet and ankles was unremarkable with no evidence of pain, crepitation, or contracture.
- Both lower extremities were stable, with no signs of dislocation, subluxation, or laxity.
- Muscle strength and tone were unremarkable, bilaterally.

G57.61, G57.62 Subsequent Exam

Physical findings:

- **Integumentary**
  - inspection and palpation of the skin is unremarkable, bilaterally especially where the previous injections were administered
- **Neurological**
  - sensation: using a pin, the 3rd and 4th toes of both feet exhibited parasthesias; otherwise the examination for sensation was unremarkable, bilaterally
  - motor: lower extremities were otherwise normal
  - gait and stance: difficulty with ambulation was observed
  - reflexes: left ankle reflex was +2/+4; right ankle reflex was +2/+4

G57.61, G57.62 Subsequent Exam

- **Assessment:** Morton's neuroma, 3rd interspace, both feet with difficulty in walking
- **Plan:** I discussed with the patient that the neuroma in the 3rd interspace of both feet did not respond well to the steroid injection. I explained to the patient what a neuroma was, again. I explained that the last mode of treatment was surgical intervention, either a decompression of the intermetatarsal ligament or excision of the neuroma. I suggested a sclerosing injection to be administered. The orthotics were dispensed and the break in schedule was explained to the patient. If this conservative regimen does not provide relief of the symptomatology, then surgical intervention will be explored.

G57.61, G57.62 Subsequent Exam

- **Procedure:** Injection of the 3rd interspace of both feet each with 0.5cc of a 30% mixture of 0.5% Marcaine(plain) and dehydrated alcohol under ultrasound guidance for best placement of this destructive injection

G57.61, G57.62 Subsequent Exam

ICD-9	ICD-10
355.6 Morton's neuroma	G57.61 Lesion of plantar nerve, right lower limb
	G57.62 Lesion of plantar nerve, left lower limb
781.2 Abnormality of gait	R26.2 Difficulty with walking, not elsewhere classified

G57.61, G57.62 Subsequent Exam

Rules for Gait:

R26 Abnormalities of gait and mobility

Excludes 1: ataxia NOS (R27.0)

hereditary ataxia (G11.-)

locomotor (syphilitic) ataxia (A52.11)

immobility syndrome (paraplegic) (M62.3)

R26.0 Ataxic gait

staggering gait

R26.1 Paralytic gait

spastic gait

G57.61, G57.62 Subsequent Exam

R26.2 Difficulty in walking, not elsewhere classified

Excludes 1: falling (R29.6)

unsteadiness on feet (R26.81)

R26.8 Other abnormalities of gait and mobility

R26.81 unsteadiness on feet

R26.89 other abnormalities of gait and mobility

R26.9 Unspecified abnormalities of gait and mobility

G57.61, G57.62 Sequela Exam

- **Chief complaint:** " I have more pain and my toes are numb."

- **Course**- symptoms increase with weight bearing and ambulation, as well as with shoe pressure; patient relates that it has gotten worse

- **Previous treatment**- includes this patient went to the VA and saw a DPM: X-rays taken and received 2 pair of inserts; received steroid injections and then sclerosing alcohol injections 2 weeks ago; received orthotics

G57.61, G57.62 Sequela Exam

Physical findings:

- **Musculoskeletal**
  - The patient's gait is guarded, bilaterally.
  - There is increased pain upon palpation within the 3rd interspace of both feet. A positive Mulder's Sign is elicited upon palpation, bilaterally within the 3rd interspace.
  - The range of motion of both feet and ankles was unremarkable with no evidence of joint pain, crepitation, or contracture.
- **Integumentary**
  - Inspection and palpation of the skin is unremarkable, bilaterally. No reactions noted from previous injections.

G57.61, G57.62 Sequela Exam

Physical findings continued:

- **Neurological-**
  - sensation: using a pin, the 3rd and 4th toes of both feet exhibited parasthesias; otherwise the examination for sensation was unremarkable, bilaterally
  - motor: lower extremities were otherwise normal
  - gait and stance: antalgic and limping gait was observed
  - reflexes: left ankle reflex was +2/+4 right ankle reflex was +2/+4

- **Assessment:** Morton's neuroma, 3rd interspace, both feet with worsening of symptoms and antalgic gait unsteadiness

G57.61, G57.62 Sequela Exam

- **Plan:** I discussed with the patient that the neuromas in the 3rd interspace of both feet have not responded to the steroid injections or the sclerosing injections. I explained to the patient that the diagnosis is still neuromas, as I just reviewed the previous ultrasounds and the width of the growth is 6mm and the length 2.2cm. I explained that the next treatment is surgical intervention, and in this case I do not feel that a decompression of the intermetatarsal ligament will work and that excision of the neuromas is necessary. I proceeded to review surgical intervention, discussed potential complications and post op course.

G57.61, G57.62 Sequela Exam

ICD-9	ICD-10
355.6 Morton's neuroma	G57.61 Lesion of plantar nerve, right lower limb
	G57.62 Lesion of plantar nerve, left lower limb
781.2 Abnormality of gait	R26.2 Difficulty with walking, not elsewhere classified

G60.0 (Charcot-Marie-Tooth Disease)

G60.0 Initial Exam

- **Chief Complaint: “** My ankles are weak, painful, and it’s difficult to walk.”
- **Consultation:** Referring physician: Dr. XXXXXX
- **History of present illness:**
  - Duration- months to years
  - Onset- insidious
  - Location- both feet and ankles
  - Nature- aching and throbbing in both ankles
  - Symptoms- increase with weight bearing and ambulation. The symptomatology is progressive.

G60.0 Initial Exam

- **History of present illness continued:**
  - The patient used a cane to ambulate.
  - Previous treatment- regularly sees a neurologist; has been using a rigid, hard plastic KAFO, bilaterally; poor shoe fit and irritating the ankles
- **Past medical/surgical history:**
  - Medical- past medical history reviewed: Charcot-Marie-Tooth Disease

G60.0 Initial Exam

Physical findings:

- **General appearance**

  Well appearing; alert, oriented to time, place, and person

  Vital signs: height: 5'11" weight: 152 lbs.

  BP: 117/68 pulse: 80/minute

- **Cardiovascular**

  Arterial pulses: dorsalis pedis and posterior tibial pulses are +2/+4, bilaterally

  Edema: there is +2 non-pitting edema over the lateral aspect of both ankles

G60.0 Initial Exam

- **Musculoskeletal system**
  - In the resting state, the patient's feet are adducted at the ankle. It is difficult for the patient to prevent his feet from going into the adducted attitude.
  - The patient ambulates with the aid of a walker. He did ambulate with a cane in lieu of the walker. His gait is antalgic and very, tentative. His gait is shuffling and adducted.
  - Inspection and palpation of the digits did not reveal clubbing, inflammatory conditions, ischemia, or infection. However, all of the toes on both feet are contracted, with hammering.
  - Both feet and ankles were examined. Inspection and palpation did not reveal the presence of any misalignment, asymmetry, crepitation, defects, masses, or effusions. There was pain upon palpation over the lateral aspect of both ankles.

G60.0 Initial Exam

- **Musculoskeletal system**
  - Both feet and ankles were put through a range of motion. There was no evidence of pain, contracture, or crepitation. The patient is not able to actively dorsiflex either of his feet. Both of the patient's feet can be passively dorsiflexed, however, when they are released, the immediately return to an adducted, plantarflexed state. Both feet have a high arch.
  - Stability of both lower extremities was assessed. There is evidence of ligamentous laxity, laterally, bilaterally.
  - There is definite muscle weakness, bilaterally as evidenced by the patient's inability to actively dorsiflex his feet and the fact that the feet remain in an adducted position.

G60.0 Initial Exam

- **Integumentary**
  - Inspection and palpation of the skin demonstrates that there is irritation on the lateral aspect of both ankles.
- **Neurological**
  - The deep tendon reflexes on both lower extremities were hyper reflexive, +4/+4, bilaterally
  - There was no evidence of pathological reflexes, bilaterally
  - There was normal, intact response to tactile stimulation of both legs and feet. The sensations in both remaining lower extremities are WNL.
  - Gait and stance: see musculoskeletal examination

G60.0 Initial Exam

- **Radiological examination:** 3 views of both ankles were taken in the weight bearing position. Soft tissue swelling is observed over the lateral aspect of both ankles. Signs of DJD are observed within the ankle joint, bilaterally. This is demonstrated by joint space narrowing, bony sclerosis, and spurring. This is most evident on the lateral aspect of the ankle joint. The lateral view demonstrates a significant cavus deformity present, bilaterally. There is a significant increase in the declination of the metatarsals on both feet. All of the toes on both feet are contracted, with hammering.

- **Assessment:** Charcot-Marie-Tooth Disease; Drop foot deformity; Difficulty in walking

G60.0 Initial Exam

- **Plan:** The patient would do best with a custom made AFO for both ankles, as opposed to the plastic KAFO's for both lower extremities. The AFO would go proximally to just below the tibial tubercle. The AFO's would provide correction in all three body planes, frontal, sagittal, and transverse. The AFO's would place the foot at the proper position in relation to the ankle, 90 degrees. This would correct the transverse plane deformity of the feet being perpetually adducted at rest and with ambulation. This would correct the sagittal plane deformity of a bilateral foot drop situation. The frontal plane deformity would be corrected by allowing the patient to proceed as appropriately as possible through the gait cycle. The gait would be less tentative with less guarding. The patient would still need the aid of the walker of the cane for ambulation. However, the patient would improve positionally, with his gait, and the overall function of both lower extremities would improve, as well.

G60.0

ICD-9	ICD-10
356.1 Charcot-Marie-Tooth Disease	G60.0 Charcot-Marie-Tooth Disease
736.79 Drop foot	M21.371 Foot drop, right foot
	M21.372 Foot drop, left foot
719.7 Difficulty with walking	R26.0 Ataxic gait

G60.0 Subsequent Exam

- **Chief complaint:** My ankles are really bothering me. They are weak, painful, it's difficult to walk, and I'm very, unsteady."
- **Previous treatment:** Regularly sees a neurologist; has ben using a rigid, hard plastic KAFO, bilaterally
  - Poor shoe fit and irritating ankles
  - Initial history and examination performed last week, including radiological examination of both ankles
  - Patient was explained that he would do best with custom made AFO's for both ankles

G60.0 Subsequent Exam

Physical findings:

- **Cardiovascular**
  - Arterial pulses: dorsalis pedis and posterior pulses are +2/+4, bilaterally
  - Edema: there is +2 non-pitting edema over the lateral aspect of both ankles

G60.0 Subsequent Exam

- **Musculoskeletal system**
  - In the resting state, the patient's feet are adducted at the ankle. It is difficult for the patient to prevent his feet from going into the adducted attitude.
  - The patient ambulates with the aid of a walker. He did ambulate with a cane in lieu of the walker. His gait is antalgic and very, tentative. His gait is shuffling and adducted.
  - Inspection and palpation of the digits did not reveal clubbing, inflammatory conditions, ischemia, or infection. However, all of the toes on both feet are contracted, with hammering.
  - Both feet and ankles were examined. Inspection and palpation did not reveal the presence of any misalignment, asymmetry, crepitation, defects, masses, or effusions. There was pain upon palpation over the lateral aspect of both ankles.

G60.0 Subsequent Exam

- **Musculoskeletal system (continued)-**
  - Both feet and ankles were put through a range of motion. There was no evidence of pain, contracture, or crepitation. The patient is not able to actively dorsiflex either of his feet. Both of the patient's feet can be passively dorsiflexed, however, when they are released, they immediately return to an adducted, plantarflexed state.
  - Stability of both lower extremities was assessed. There is evidence of ligamentous laxity, laterally, bilaterally.
  - There is definite muscle weakness, bilaterally as evidenced by the patient's inability to actively dorsiflex his feet and the fact that both feet remain in an adducted position.

G60.0 Subsequent Exam

- **Integumentary**
  - Inspection and palpation of the skin demonstrates that there is evidence of irritation on the lateral aspect of both ankles
- **Neurological**
  - The deep tendon reflexes on both lower extremities were hyper reflexive, +4/+4, bilaterally
  - There was no evidence of pathological reflexes, bilaterally
  - There was normal intact response to tactile stimulation of both legs and feet; the sensations in both remaining lower extremities are WNL
  - Gait and stance: see musculoskeletal examination

G60.0 Subsequent Exam

- **Assessment:**

  Charcot-Marie-Tooth Disease

  Drop foot deformity

  Difficulty in walking

- **Plan:** I once again discussed with the patient that he would do best with custom made AFO's for both ankles. The AFO's would extend proximally to the tibial tubercle of both lower extremities. These devices would improve the patient positionally, improve his gait, and improve the overall function of both lower extremities.

G60.0 Subsequent Exam

- **Procedure:** The patient was casted today for custom made AFO's for both lower extremities with the appropriate additions and modifications. The casts were sent to the laboratory for fabrication. The patient will return in two weeks to be fitted with the devices.

G60.0 Subsequent Exam

ICD-9	ICD-10
356.1 Charcot-Marie-Tooth Disease	G60.0 Charcot-Marie-Tooth Disease
736.79 Drop Foot	M21.371 Foot drop, right foot
	M21.372 Foot drop, left foot
719.7 Difficulty with walking	R26.0 Ataxic gait

G60.0 Sequela Exam

- **Chief complaint:** " My ankles are really bothering me. They are weak, painful, it's difficult to walk, and I'm very unsteady."
- **Previous treatment:**
  - Initial history and examination were performed, including radiological examination of both ankles
  - Patient was explained that he would do best with custom made AFO's for both ankles
  - Patient was casted on the last encounter for custom made AFO's for both lower extremities with the appropriate additions and corrections

G60.0 Sequela Exam

Physical findings:

- **Musculoskeletal system**
  - In the resting state, the patient's feet are adducted at the ankle. It is difficult for the patient to prevent his feet from going into the adducted attitude.
  - The patient ambulates with the aid of a walker. He did ambulate with a cane in lieu of the walker. His gait is antalgic and very, tentative. His gait is shuffling and adducted.

G60.0 Sequela Exam

- Inspection and palpation of the digits did not reveal clubbing, inflammatory conditions, ischemia, or infection. However, all of the toes on both feet are contracted, with hammering.
- Both feet and ankles were examined. Inspection and palpation did not reveal the presence of any misalignment, asymmetry, crepitation, defects, masses, or effusions. There was pain upon palpation over the lateral aspect of both ankles.
- Both feet and ankles were put through a range of motion. There was no evidence of pain, contracture, or crepitation. The patient is not able to actively dorsiflex either of his feet. Both of the patient's feet can be passively dorsiflexed, however, when they are released, the immediately return to an adducted, plantarflexed state.

G60.0 Sequela Exam

- **Musculoskeletal system (continued)**
  - Stability of both lower extremities was assessed. There is evidence of ligamentous laxity, laterally, bilaterally.
  - There is definite muscle weakness, bilaterally as evidenced by the patient's inability to actively dorsiflex his feet and the fact that both feet remain in an adducted position.

- **Integumentary**
  - Inspection and palpation of the skin shows that there is evidence of irritation on the lateral aspect of both ankles

G60.0 Sequela Exam

- **Neurological**
  - The deep tendon reflexes on both lower extremities are hyper reflexive, +4/+4
  - There is no evidence of pathological reflexes, bilaterally
  - There was normal intact response to tactile stimulation of both feet and legs
  - The remaining sensations in both lower extremities are WNL
  - Gait and stance: see musculoskeletal examination
- **Assessment**
  - Charcot-Marie-Tooth Disease
  - Drop foot deformity
  - Difficulty in walking

G60.0 Sequela Exam

- **Plan:** I once again discussed with the patient that he would do best with custom made AFO's for both ankles. The AFO's would extend proximally to the tibial tubercle of both lower extremities. These devices would improve the patient positionally, improve his gait, and improve the overall function of both lower extremities. The patient was instructed in the care and the use of the AFO's. The patient will additionally receive instructions in writing.

G60.0 Sequela Exam

- **Procedure:** The patient was dispensed and fitted with the AFO's for both lower extremities. The use of proper socks and foot wear were explained carefully. The patient was instructed in the appropriate break in period for the use of the devices. If any increase in pain or additional irritation arises, he is to contact the office ASAP and to discontinue the use of the devices until seen in the office. He is to return in two weeks if no issues arise.

G60.0 Sequela Exam

ICD-9		ICD-10	
356.1	Charcot-Marie-Tooth Disease	G60.0	Charcot-Marie-Tooth Disease
736.79	Drop foot	M21.371	Foot drop, right foot
719.7	Difficulty with walking	M21.372	Foot drop, left foot
		R26.0	Ataxic gait

New CMS 1500 Form

NUCC CMS 1500 2/12

- #17 Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.
- If multiple providers are involved, enter one provider using the following priority order:
    1. Referring Provider
    2. Ordering Provider
    3. Supervising Provider

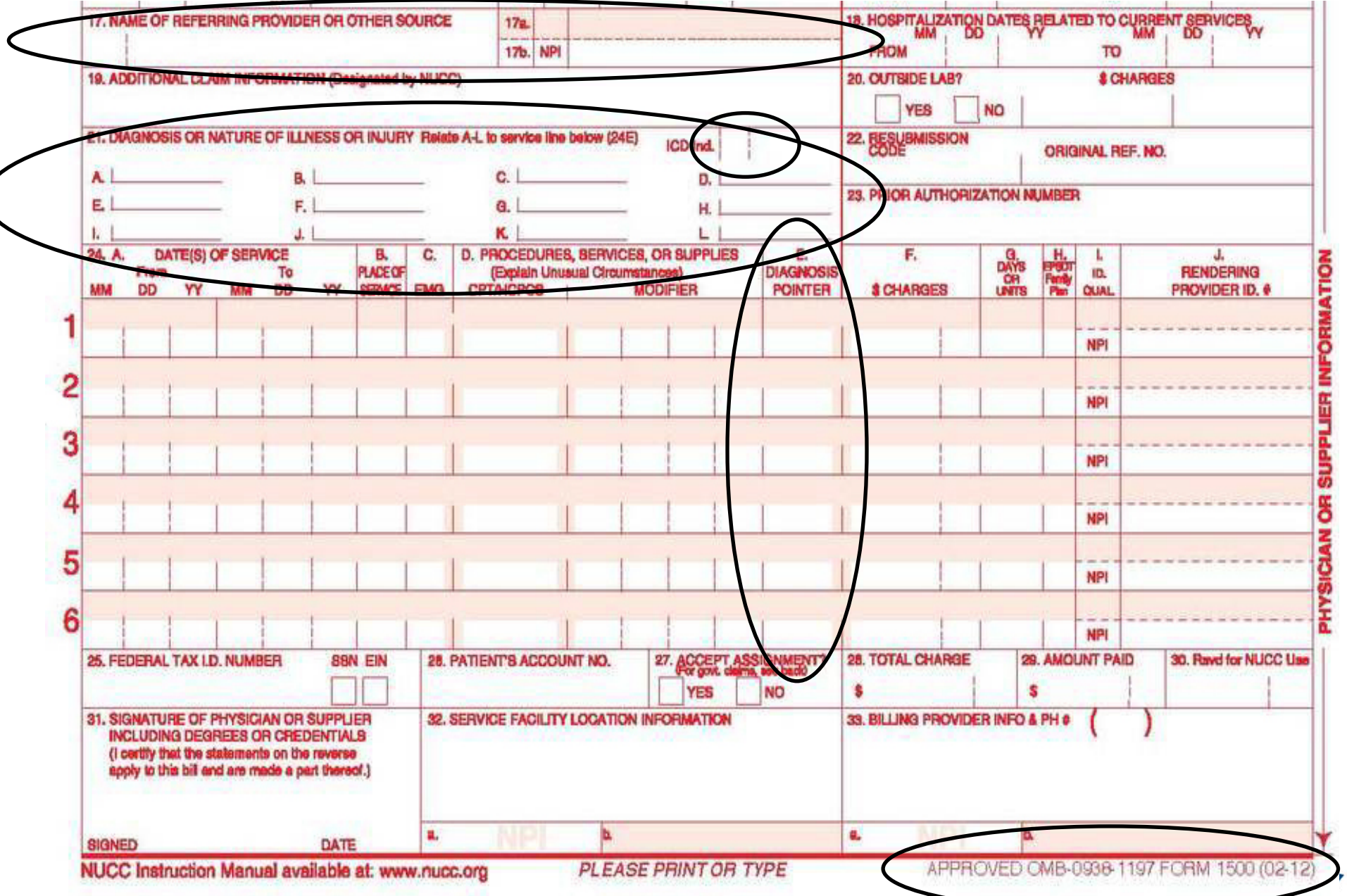
NUCC CMS 1500 2/12

- Do not use periods or commas. A hyphen can be used for hyphenated names.
- Enter the applicable qualifier to identify which provider is being reported.

  DN – Referring Provider

  DK – Ordering Provider

  DQ – Supervising Provider



17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL | J. RENDERING PROVIDER ID. #
1 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.
PHYSICIAN OR SUPPLIER INFORMATION
NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)

Next Webinar

Infectious Diseases and Disorders (A00-B099)

Thursday, September 19, 2014 at 8:00 PM ET

Presented by Jon Goldsmith, DPM

Register at www.apma.org/icd10ishere

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ICD-10 IS HERE WEBINAR APMA