ICD-10-CM
Specialty Code Set Training
Orthopaedics

2014

Module 1

AAPC
Advancing the Business of Healthcare

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Clinical Examples Used in this Book

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

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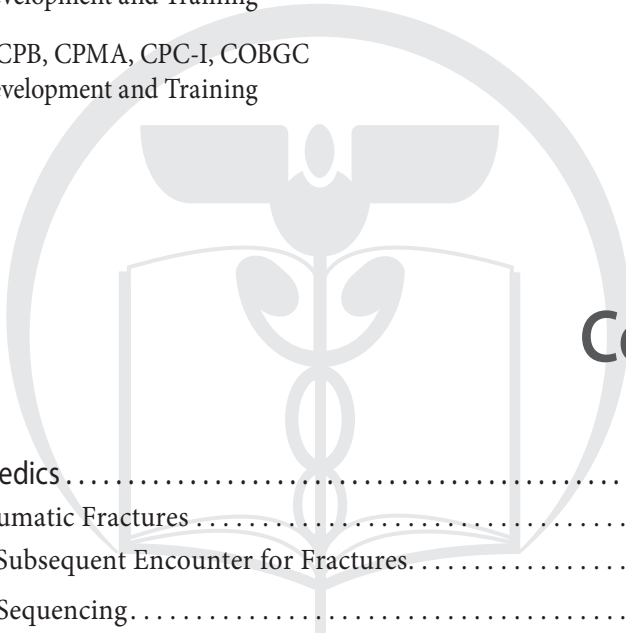
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Contents

Injuries in Othopaedics

Coding of Traumatic Fractures

The type and number of fractures that can occur are wide and varied. The codes for fractures have greatly expanded in ICD-10-CM due to the specificity of site, inclusion of laterality, nature of the fracture (transverse, oblique, comminuted, segmental, etc), and 7th character extender additions. To accurately assign fracture codes the documentation should provide information about each of these specificities as well the following:

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

In ICD-10-CM the traumatic fractures codes are located in Chapter 19, Injury, Poisoning and Certain Other Consequences of External Causes While the level of specificity and expansion of codes for traumatic fractures and other injuries in Chapter 19 make memorization of the codes very difficult, the format and structure of the codes found in chapter 19 both provide a logical approach that over time will become quite easy to use.

Whereas in ICD9 the injury chapter was formatted by type of injury, in ICD-10-CM the injury chapter is arranged first anatomically. So instead of finding all the fracture codes listed together, fractures will be found within the appropriate anatomical location of the injury based on the documentation. Another consistency that can be found when coding for fractures will be in the code itself. Each character within a code identifies a unique component of the specificity found in that injury. Within most of chapter 19 the second character identifies the general anatomic site, the third character the general type of injury, the fourth and fifth character will further specify the anatomic site or type of injury and the sixth character indicates the laterality of the injury.

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

EXAMPLE

S42.151A Displaced fracture of neck of scapula, right shoulder, initial encounter closed fracture

S43.151A Posterior dislocation of right acromioclavicular joint, initial encounter

S72.25XA Nondisplaced subtrochanteric fracture of right femur, initial encounter closed fracture

S73.121A Ischiocapsular (ligament) sprain of right hip, initial encounter closed fracture

What the ICD-10-CM user will find, and the examples show, all injuries to the shoulder and upper arm, regardless of the type of injury, will have the second character of 4 while all injuries to the hip and thigh will have the second character of 7. The user will also find, as the examples show, the third character in all fractures, except physeal, are identified by a 2 and all dislocations and sprains of joint and ligaments are identified by a 3.

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

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

In ICD-10-CM the fracture code narratives will have both site and laterality designations. Therefore,it is important to understand the terminology used in regards to bones and types of fractures for proper code assignment. Coding of fractures can be complex without the proper anatomy knowledge.

Common terminology:

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

EXAMPLE

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

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

W14.XXXA Fall from tree, initial encounter

Below is a diagram of typical fractures.

Typical Bone Fractures

Greenstick   **Comminuted**   **Compound**

Spiral   **Transverse**

Vertebral Compression
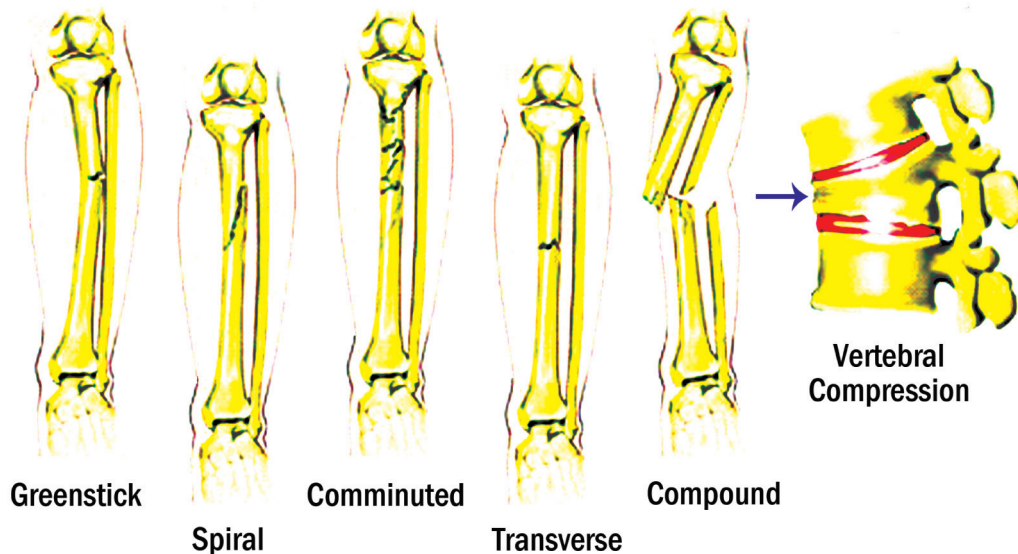
Source: AAPC

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

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

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

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

EXAMPLE

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

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

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

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

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

> **EXAMPLE**
>
> Patient is seen in ED after being involved in a traffic accident with several other vehicles. Imaging shows a three part displaced segmental fracture of the right femoral shaft. Patient is brought to the OR for ORIF of the femoral fracture.
>
> > S72.361A Displaced segmental fracture of the shaft of the right femur, initial encounter closed fracture
> >
> > V89.2XXA Person injured in unspecified motor-vehicle accident, traffic, initial encounter

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

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

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

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

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

> **EXAMPLE**
>
> S52.371F Galeazzi's fracture of right radius, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing

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

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

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

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

EXAMPLE

Patient suffered an extra-articular fracture of the right distal radius that occurred as the result of a fall onto an out stretched hand. X-ray showed a fracture of the distal radial metaphyseal region with dorsal angulation and impaction, but without involvement of the articular surface with evidence of malunion.

S52.531P Colles' fracture of right radius, subsequent encounter for closed fracture with malunion

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

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

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

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

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

EXAMPLE

S82.861A Displaced Maisonneuve's fracture of right leg, initial encounter for closed fracture

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

EXAMPLE

While painting his house, Jacob felt the foot of the ladder sink into the ground pitching the ladder to the left, causing him to lose his balance and jump to the ground from two-stories up. He is seen in the ED with left ankle and leg pain. Imaging shows a pilon fracture of the tibia and an associated comminuted fracture of the fibula.
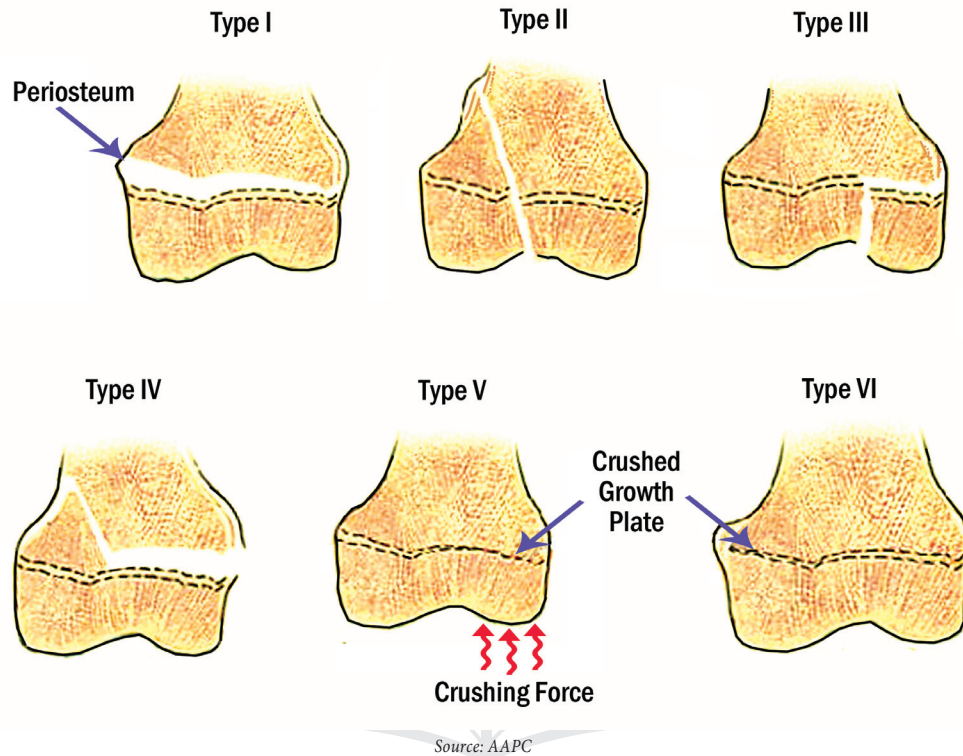
S82.872A Displaced pilon fracture of left tibia, initial encounter closed fracture

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

W11.XXXA Fall on and from ladder, initial encounter

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

Salter-Harris Fracture Classification

Type I

Periosteum

Type II

Type III

Type IV

Type V

Crushed
Growth
Plate

Type VI

Crushing Force

Source: AAPC

A Salter-Harris fracture is a traumatic fracture of the physeal and/or epiphyseal growth plate. Salter-Harris fractures occur in the extremities of children at the point where new bone is being formed as the bones grow. Salter-Harris Type I and Type II are commonly treated by family practitioners. Salter-Harris Types III–VI tend to need the care of orthopaedic specialists.

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

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

Type III Growth Plate Fracture:

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

Type IV Growth Plate Fracture:

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

Type V Growth Plate Fracture:

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

> **EXAMPLE**
>
> 15-year-old Sarah presents with a displaced fracture of the right distal femur. Plain films reviewed, the fracture is found to be within the growth plate continuing proximally approximately 12 cm through the diaphysis.
>
> > S79.122A Salter-Harris Type II physeal fracture of lower end of left femur, initial encounter closed fracture

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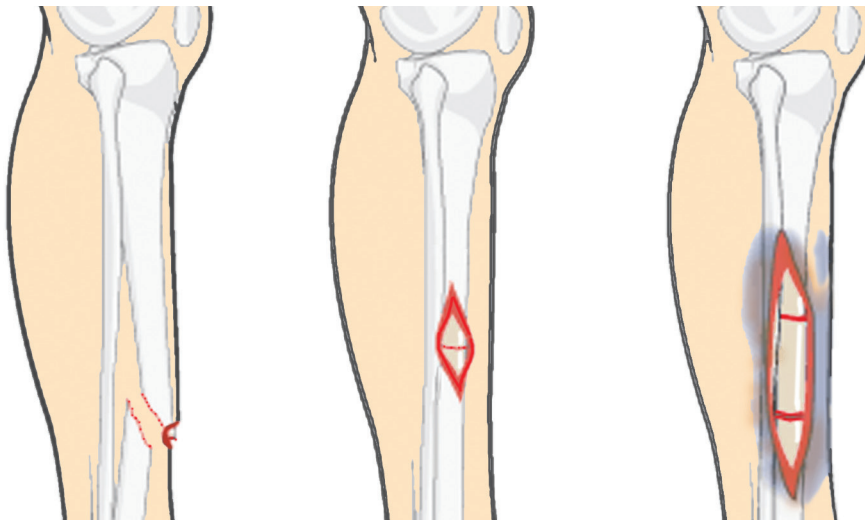
Source: AAPC

Type I

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

Type II

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

Type III

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

Type IIIA

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

Type IIIB

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

Type IIIC

Major arterial injury repair is required for limb salvation.

EXAMPLE

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

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

> S52.351C Displaced comminuted fracture of the shaft of radius, right arm, initial encounter for open fracture type IIIA
>
> S52.221C Displaced transverse fracture of shaft of right ulna, initial encounter for open fracture type IIIA
>
> V43.42XA Person boarding or alighting a car injured in collision with other type car, initial encounter

Initial vs. Subsequent Encounter for Fractures

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

CODING TIP

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

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

A initial encounter for closed fracture

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

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

EXAMPLE

A patient underwent surgery for an open burst fracture of the first lumbar vertebra, which became unstable.

S32.012B Unstable burst fracture of first lumbar vertebra

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

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

G subsequent encounter for closed fracture with delayed healing

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

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

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

K subsequent encounter for closed fracture with nonunion

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

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

P subsequent encounter for closed fracture with malunion

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

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

EXAMPLE

A patient presents for a recheck of her closed fracture of the neck of the left radius. X-rays are

taken and show a malunion of the fracture.

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

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

EXAMPLE

Mr. Johnson presents with complaints of left hip pain. He is six months post total replacement
of same. He states that the pain is constant and if he sleeps on his left side he is woken at night
by a stabbing pain at the upper end of his thigh. After examining the area and reviewing films,
the orthopaedist diagnosis the condition as pain due to prosthetic hip.

ICD-10-CM: T84.84XD Pain due to internal orthopedic prosthetic devices, implants and
grafts, subsequent encounter

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

EXAMPLE

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

M87.221 Osteonecrosis due to previous trauma, right humerus
S42.351S Displaced comminuted fracture of shaft of humerus, right arm, sequela

Fractures Sequencing

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

Dislocations

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

Joint Luxation and Subluxation

| Normal | Subluxation
(Nursemaid's elbow) | Luxation |
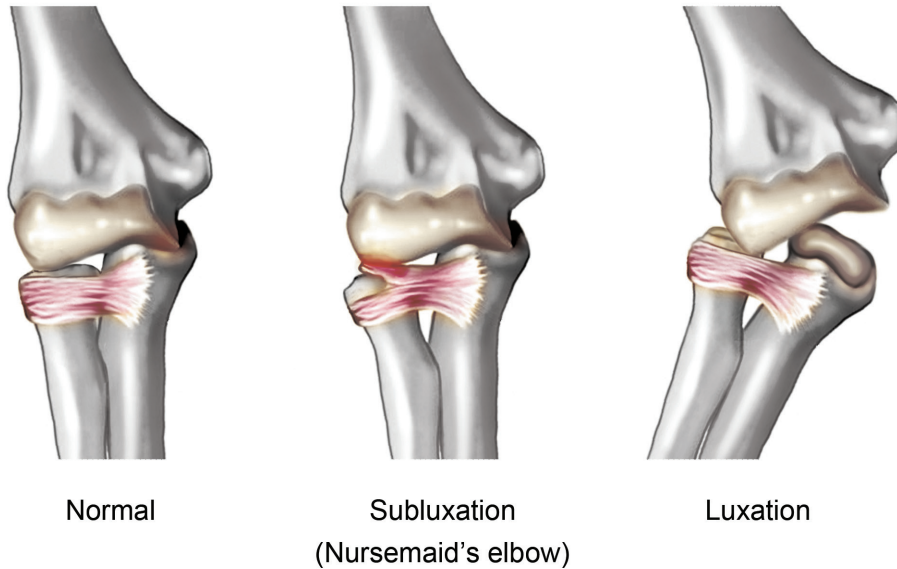
Source: AAPC

To assign a code to the highest level of specificity for a dislocation the documentation should be reviewed for information related to:

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

Dislocation Positions

Normal   Anterior   Posterior

Inferior   Laterally
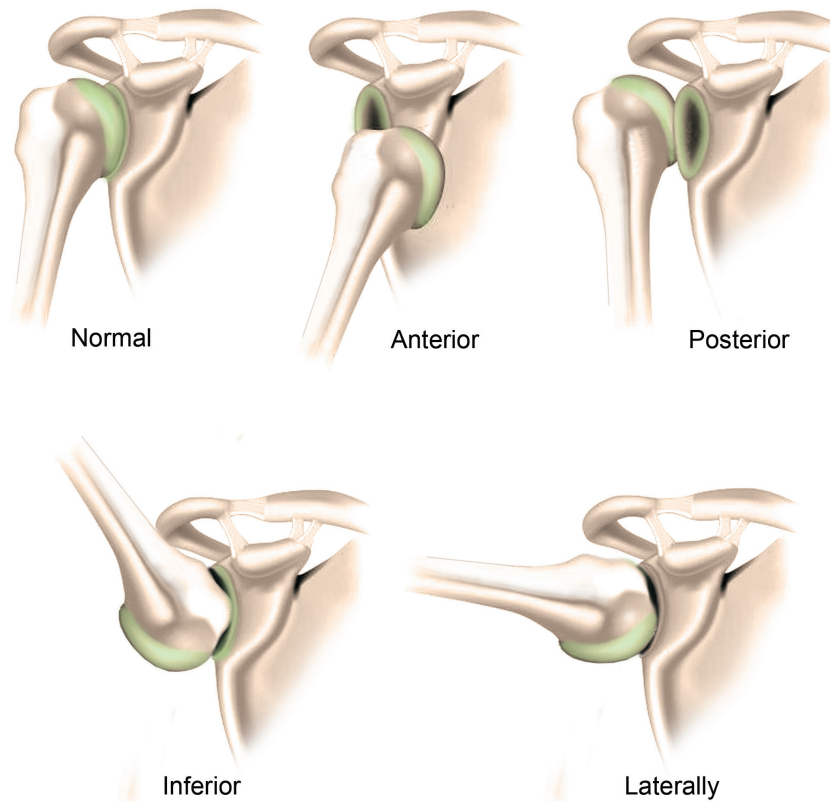
Source: AAPC

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

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

EXAMPLE

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

Assessment: Anterior partial dislocation of right humerus

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

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

EXAMPLE

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

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

ICD-10-CM: S43.015A Anterior dislocation of left humerus, initial encounter
S41.042A Puncture wound with foreign body of left shoulder, initial encounter

Traumatic Connective Tissue and Muscle Injuries

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

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

Common terminology

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

EXAMPLE

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

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

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

Y93.67 Activity, basketball

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

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

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

EXAMPLE

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

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

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

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

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

EXAMPLE

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

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

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

Y93.66 – Activity soccer

External Cause Codes for Injuries

The Official Coding Guidelines states that the guidelines for reporting external causes are provided in order that there will be standardization in the process. These codes are secondary codes for use in any healthcare setting. External cause codes are not required for reporting to some third-party payers. NOTE: Suggest starting this section with this paragraph. There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code-reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies. The use of these codes could simplify administrative paperwork by spelling out the complete clinical condition of the patient and the circumstances surrounding the illness or injury. It will be up to the coder to work with individual healthplans to determine reporting requirements.

General External Cause Coding Guidelines

External Cause Code Used for Length of Treatment

Assign the external cause code with the appropriate seventh character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated. This is a new concept in diagnostic coding. The 7th character chosen represents the status of the patient during the active treatment or recovery process.

Place of Occurrence Guideline

Codes from category Y92, Place of occurrence of the external cause, are secondary codes for use after other external cause codes to identify the location of the patient at the time of injury or other condition. The available place of occurrence codes has substantially increased in ICD-10-CM. For example, mobile home, apartment, military base, hospital, and cultural building with specific sites in those places have separate codes in ICD-10-CM.

A place of occurrence code is used only once at the initial encounter for treatment. No seventh characters are used for Y92. Only one code from Y92 should be recorded on a medical record. A place of occurrence code should be used in conjunction with an activity code, Y93. Do not use place of occurrence code Y92.9 *Unspecified place or not applicable*, if the place is not stated or is not applicable.

Activity Code

Codes from category Y93, Activity code, are secondary external cause codes for use with other external cause codes to identify the activity of the patient at the time of the injury.

An activity code is used only once, at the initial encounter for treatment. Only one code from Y93 should be recorded on a medical record. An activity code should be used in conjunction with a place of occurrence code, Y92.

If a patient is a student but is injured while performing an activity for income, use seventh character 2, work related activity. A work related activity is any activity for which payment or

income is received. Use activity code Y93.9 if the activity of the patient is not stated or is not applicable. A code from category Y93 is appropriate for use with external cause and intent codes if identifying the activity provides additional information about the event.

Place of Occurrence and Activity Code Used with Other External Cause Code

When applicable, a place of occurrence and an activity code are sequenced after the main external cause code(s). Regardless of the number of external cause codes assigned there should be only one place of occurrence code and one activity code assigned to an encounter.

> **EXAMPLE**
>
> Pat was roller skating at the city park when her skate hit a crack in the pavement causing her to fall and sprain the calcaneofibular ligament of her right ankle.
>
> S93.411A Sprain of calcaneofibular ligament of right ankle, initial encounter
>
> V00.121A Fall from non-in-line skates, initial encounter
>
> Y92.830 Public park as the place of occurrence of the external cause
>
> Y93.51 Activity, roller skating (inline) and skateboarding
>
> Y99.8 Other external cause status

External Cause Status

A code from category Y99 should be assigned whenever any other external cause code is assigned for an encounter including an Activity code. Assign a code from category Y99, External cause status, to indicate the work status of the person at the time the event occurred.

Do not assign a code from category Y99 for:

Poisonings

Adverse effects

Misadventures

Late effects

Do not assign code Y99.9 *Unspecified external cause status* if the status is not stated in the medical record.

An external cause status code is used only once, at the initial encounter for treatment. Only one code from Y99 should be recorded on a medical record.