Spine
ICD-10 Analysis
## Agenda

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<th>ICD-10 CM and PCS Structure</th>
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<td>Documentation Analysis</td>
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<td>- Compression Fracture</td>
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<td>- Diskectomy</td>
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<td>- Disk Herniation</td>
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<td>- Spondylolisthesis</td>
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<td>- Spinal Stenosis</td>
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<td>- Degenerative Disk Disease</td>
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<td>- Herniation and Degeneration</td>
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<td>- Spinal Fusion</td>
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<tr>
<td>Documentation Tips - Major Diagnosis</td>
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<tr>
<td>Documentation Tips - Procedures</td>
</tr>
</tbody>
</table>
**Acuity** - acute, chronic, intermittent

**Severity** - mild, moderate, severe

**Etiology** - trauma, diabetes, renal failure, exercise or infection induced

**Location** - where is it? Be specific about which joint, chest, femur, posterior thorax

**Laterality** - which side is it? Left, right, both?

**Detail:** Present on admission status, associated symptoms (hypoxia, loss of consciousness), additional medical diagnoses, initial versus subsequent encounter
If you like mnemonics…

Any: Acuity
Small: Severity
Error: Etiology
Loses: Location
Large: Laterality
Dollars: Detail- Present on admission status, associated symptoms, additional medical diagnoses, initial versus subsequent encounter
ICD-10 CM

- Diagnosis classification system developed by the Centers for Disease Control and Prevention for use in all U.S. health care treatment settings
- ICD 10 CM codes can have 3, 4, 5, 6 or 7 characters (alphanumeric)

A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.
ICD-10 PCS codes are composed of seven characters. Each character is an axis of classification that specifies information about the procedure performed.

Character 1: Section
- Medical and Surgical

Character 2: Body System
- 31 Body system

Character 3: Root Operation
- 31 Root Operations
  - The root operation identifies the objective of the procedure.

Character 4: Body Part
- Indicates specific part of body system

Character 5: Approach
- Technique used to reach the site of procedure.

Character 6: Device
- Used to specify device that remains after the procedure is complete

Character 7: Qualifier
- Unique values for individual procedures

<table>
<thead>
<tr>
<th>Name</th>
<th>ICD-10 PCS coding</th>
<th>Medical and surgical</th>
<th>Upper joints</th>
<th>Fusion</th>
<th>Body part (Thoracic vertebral joint)</th>
<th>Approach (Open)</th>
<th>Device (Interbody fusion device)</th>
<th>Qualifier (Anterior approach anterior column)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal fusion</td>
<td>0RG60A0</td>
<td>0</td>
<td>R</td>
<td>G</td>
<td>6</td>
<td>0</td>
<td>A</td>
<td>0</td>
</tr>
</tbody>
</table>

In ICD-10 PCS, the term “procedure” refers to the complete specification of the seven characters.
<table>
<thead>
<tr>
<th>• Compression vertebral fractures have additional classification based on the cause, specific site along with encounter type.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnosis coding and documentation of disc herniation (displacement), disc degeneration, and spinal stenosis have increased codes depending on anatomic sites.</td>
</tr>
<tr>
<td>• Disc displacement coding, in addition to anatomic site detail there is the optional ability to code associated radiculopathy, if present.</td>
</tr>
<tr>
<td>• Specificity of codes for congenital abnormality has increased in ICD-10. There are specific codes available for kyphosis, lordosis, scoliosis etc. as compared to unspecified codes in ICD-9.</td>
</tr>
<tr>
<td>• ICD-10 code for bone marrow biopsy (extraction) requires to specifies body part as iliac, sternum, or vertebra, and the approach of biopsy as percutaneous or open.</td>
</tr>
<tr>
<td>• ICD-10 requires to specify the vertebral joint, the type of fusion device used, the approach used and the column fused.</td>
</tr>
<tr>
<td>• ICD-10 requires to specify diskectomy as partial or complete removal of the disk.</td>
</tr>
</tbody>
</table>

With ICD-10 CM, the number of diagnosis codes increases from approximately 13,000 to 68,000, and with much greater detail in diagnosis-code descriptions, along with the creation of diagnosis codes that combine conditions, manifestations, and complications into a single code.
Compression fractures may be due to either disease or to trauma. The coder should search the medical record for any recent significant trauma or for any indication of concurrent bone disease that might point to pathological fracture. If the diagnosis cannot be clarified, the physician should be asked to provide further specificity.
<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>733.13 Pathological fracture of vertebra</td>
<td>M48.46 Fatigue fracture of vertebra, lumbar</td>
</tr>
<tr>
<td></td>
<td>XA - initial encounter of fracture</td>
</tr>
<tr>
<td></td>
<td>XD - subsequent encounter for fracture with routine healing</td>
</tr>
<tr>
<td></td>
<td>XG - subsequent encounter for fracture with delayed healing</td>
</tr>
<tr>
<td></td>
<td>XS - sequela of fracture</td>
</tr>
<tr>
<td></td>
<td>M48.56 Collapsed vertebra, NOS, lumbar region</td>
</tr>
<tr>
<td></td>
<td>XA - initial encounter of fracture</td>
</tr>
<tr>
<td></td>
<td>XD - subsequent encounter for fracture with routine healing</td>
</tr>
<tr>
<td></td>
<td>XG - subsequent encounter for fracture with delayed healing</td>
</tr>
<tr>
<td></td>
<td>XS - sequela of fracture</td>
</tr>
<tr>
<td></td>
<td>M80.08 Age related osteoporosis with current pathological fracture, vertebra</td>
</tr>
<tr>
<td></td>
<td>XA - initial encounter of fracture</td>
</tr>
<tr>
<td></td>
<td>XD - subsequent encounter for fracture with routine healing</td>
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<td></td>
<td>XG - subsequent encounter for fracture with delayed healing</td>
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<tr>
<td></td>
<td>XS - sequela of fracture</td>
</tr>
<tr>
<td></td>
<td>M80.88 Drug induced osteoporosis with current pathological fracture, vertebra</td>
</tr>
<tr>
<td></td>
<td>XA - initial encounter of fracture</td>
</tr>
<tr>
<td></td>
<td>XD - subsequent encounter for fracture with routine healing</td>
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<td></td>
<td>XG - subsequent encounter for fracture with delayed healing</td>
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<tr>
<td></td>
<td>XS - sequela of fracture</td>
</tr>
<tr>
<td></td>
<td>M84.48 Pathological fracture</td>
</tr>
<tr>
<td></td>
<td>XA - initial encounter of fracture</td>
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<tr>
<td></td>
<td>XD - subsequent encounter for fracture with routine healing</td>
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<tr>
<td></td>
<td>XG - subsequent encounter for fracture with delayed healing</td>
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<tr>
<td></td>
<td>XS - sequela of fracture</td>
</tr>
<tr>
<td></td>
<td>M84.58 Pathological fracture in neoplastic disease, other specified site, initial encounter for fracture</td>
</tr>
<tr>
<td></td>
<td>XA - initial encounter of fracture</td>
</tr>
<tr>
<td></td>
<td>XD - subsequent encounter for fracture with routine healing</td>
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<td></td>
<td>XG - subsequent encounter for fracture with delayed healing</td>
</tr>
<tr>
<td></td>
<td>XS - sequela of fracture</td>
</tr>
</tbody>
</table>
Case Study – Diskectomy

Operative report

PREOPERATIVE DIAGNOSES:
1. Degenerative lumbar scoliosis, L2-S1.
2. Degenerative spondylolisthesis, L4-S1.
3. Foraminal and central and lateral recess stenosis, L2-L3, L3-L4, L4-L5, and L5-S1.

POSTOPERATIVE DIAGNOSES:
1. Degenerative lumbar scoliosis, L2-S1.
2. Degenerative spondylolisthesis, L4-S1.
3. Foraminal and central and lateral recess stenosis, L2-L3, L3-L4, L4-L5, and L5-S1.

PROCEDURE:
Anterior lumbar interbody fusion with placement of interbody fusion devices L2-L3, L3-L4, L4-L5, and L5-S1 with anterior buttress plate fixation for stabilization of previously placed anterior grafts, L4-L5 and L5-S1.

IMPLANTS:
Integra aPOD PEEK interbody fusion devices L4-L5 and L5-S1 with spin plate anterior buttress plate fixation system L4-L5 and L5-S1. Additional implants were Integra aPOD-L PEEK intervertebral fusion devices L2-3 and L3-4.

DESCRIPTION OF PROCEDURE:
The patient was taken to the operating room, placed in a supine position on the operating table where general anesthesia obtained. The patient was then carefully positioned to allow anterior approach to the lumbar spine via an anterior retroperitoneal approach. Once the patient was appropriately positioned, intraoperative Fluoroscopy was brought in to confirm appropriate visualization of the operative levels of both L4-L5 and L5-S1. The abdomen was then prepped and draped, a surgical time-out was completed, and Dr. Ralph Gillen was then performed anterior approach to the lumbar spine at L4-L5 and L5-S1 and this will be dictated under separate operative note. Once appropriate exposure of the lumbar disk spaces L4-L5 and L5-S1 were able to be achieved and radiographically confirmed with intraoperative Fluoroscopy, amnulotomy was first performed at L4-L5. Serial coverage of the disk space was then performed and then a thorough diskectomy was completed removing the cartilaginous endplate leaving the bone endplates intact. Using the trial devices for the interbody implants, I was able to restore disk space height very well as well as achieve some reduction of the spondylolisthesis of L4 and L5 posteriorly with moving for slightly superiorly and posteriorly, with excellent correction of disk space height and actual correction of the degenerative scoliotic deformity taking away the concavity on the left, an appropriate sized implant was selected to match patient's anatomy, packed with a small amount of bone morphogenetic protein and some additional beta-tricalcium phosphate, and then this

Discharge summary

ADMISSION DIAGNOSIS:
Degenerative disk disease with associated spondylolisthesis and degenerative scoliosis, L2-S1.

ADMISSION PROCEDURES:
Anterior lumbar interbody fusion with instrumentation, L2-S1.

HOSPITAL COURSE:
The patient was admitted on [date] and underwent an uncomplicated surgical procedure with stand-alone anterior interbody implants placed L2-L3, L3-L4, L4-L5, and L5-S1 with buttress plate stabilization performed L4-L5 and L5-S1.

Postoperative course was uneventful. The patient tolerated oral intake by postoperative day [day]. Hemoglobin and hematocrit remained stable postoperatively. The patient was noted to have some very mild left-sided hip flexor weakness postoperatively consistent with the left-sided approach to the lumbar spine via both anterior and lateral approaches. Otherwise, she remained neurologically intact without radiculopathy. Her postoperative back pain was well controlled with initial IV medications and then transferred to oral medication regimen. She was considered stable for discharge to home with use of an external brace by postoperative day [day].

ICD-10 Documentation for diskectomy:
- Specify the body part as cervical, cervicothoracic, lumbar etc.
- Specify if partial or complete disc removed
- Specify the approach used as open, percutaneous or endoscopic.

<table>
<thead>
<tr>
<th>Name</th>
<th>ICD-10 PCS coding</th>
<th>Medical and surgical</th>
<th>Lower joints</th>
<th>Replacement</th>
<th>Body part</th>
<th>Approach (Open)</th>
<th>Device (no device)</th>
<th>Qualifier (diagnostic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disectomy</td>
<td>09^20ZZ</td>
<td>0</td>
<td>S</td>
<td>B Excision</td>
<td></td>
<td>2</td>
<td>0</td>
<td>Z</td>
</tr>
</tbody>
</table>

ICD-10 requires to specify diskectomy as partial or complete removal of the disk.
Case Study – Disk Herniation

Transfer summary

INDICATIONS:
Ginger McJunkin is a 78-year-old female with a history of a lumbar laminectomy. She developed intractable lumbosacral radiculopathies to her left lower extremity. A CT myelogram of the lumbar vertebrae revealed a far lateral left L4-S and L5-S1 disk herniation. The patient underwent conservative care, but ultimately failed. It was then indicated she undergo surgical intervention at that time.

HOSPITAL COURSE:
Postoperatively, the patient was transferred to 4 West in stable condition. Her pain was well controlled on a PCA Dilaudid. She was effectively transitioned to oral Percocet without difficulty. The patient participated in physical therapy and occupational therapy. On postoperative day three, the patient did complain of intermittent left lower extremity pain. A CT scan of the lumbar spine was performed, which showed no evidence of hardware failure or malposition. Physical therapy and occupational therapy consultation was requested. It was felt that the patient would benefit from inpatient rehab. The patient was then transferred accordingly.

H&P

CHIEF COMPLAINT:
Low back pain.

HISTORY OF PRESENT ILLNESS:
Ginger McJunkin is a pleasant 78-year-old female with a history of multiple lumbar spine surgeries, including placement of a spinal cord stimulator.

DIAGNOSIS AND MEDICAL DECISION MAKING:
Ginger McJunkin is an elderly 78-year-old female who has unfortunately failed conservative care. She complains of severe low back pain radiating down her left lower extremity. The patient has been consented for L4-S and L5-S1 lumbar decompression and posterolateral instrumented fusion.

ICD-10 Documentation for herniation:

- Specify the body part as cervical, cervicothoracic, lumbar etc.
- Specify presence of myelopathy, radiculopathy, radiculitis, neuritis etc.

ICD-10 requires to specify the presence of radiculopathy with disc herniation. Disk herniation will be coded to disk displacement. Disk herniation with radiculopathy will be coded to disk disorder with radiculopathy.
ICD-10 Documentation for spondylolisthesis:

- Specify the body part as cervical, cervicothoracic, lumbar etc.
- Specify the cause as congenital, traumatic (subluxation or dislocation), or acquired as applicable.

M43.1 Spondylolisthesis
  - M43.10 Spondylolisthesis, site unspecified
  - M43.11 Spondylolisthesis, occipito-atlanto-axial region
  - M43.12 Spondylolisthesis, cervical region
  - M43.13 Spondylolisthesis, cervicothoracic region
  - M43.14 Spondylolisthesis, thoracic region
  - M43.15 Spondylolisthesis, thoracolumbar region
  - M43.16 Spondylolisthesis, lumbar region
  - M43.17 Spondylolisthesis, lumbosacral region
  - M43.18 Spondylolisthesis, sacral and sacrococcygeal region
  - M43.19 Spondylolisthesis, multiple sites in spine

ICD-10 requires to specify the site for Spondylolisthesis.
ICD-10 Documentation for spinal stenosis:

- Specify the body part as cervical, cervicothoracic, lumbar etc.

M48.0 Spinal stenosis
  M48.00 Spinal stenosis, site unspecified
  M48.01 Spinal stenosis, occipito-atlanto-axial region
  M48.02 Spinal stenosis, cervical region
  M48.03 Spinal stenosis, cervicothoracic region
  M48.04 Spinal stenosis, thoracic region
  M48.05 Spinal stenosis, thoracolumbar region
  M48.06 Spinal stenosis, lumbar region
  M48.07 Spinal stenosis, lumbosacral region
  M48.08 Spinal stenosis, sacral and sacrococcygeal region

ICD-10 requires to specify the site for spinal stenosis.
ICD-10 Documentation for degenerative disk disease:

- Specify the body part as cervical, cervicothoracic, lumbar etc.
- Specify presence of myelopathy, radiculopathy, radiculitis, neuritis etc.

M51.0 Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with myelopathy
  - M51.04 Intervertebral disc disorders with myelopathy, thoracic region
  - M51.05 Intervertebral disc disorders with myelopathy, thoracolumbar region
  - M51.06 Intervertebral disc disorders with myelopathy, lumbar region
  - M51.07 Intervertebral disc disorders with myelopathy, lumbosacral region

M51.1 Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with radiculopathy
  - M51.14 Intervertebral disc disorders with radiculopathy, thoracic region
  - M51.15 Intervertebral disc disorders with radiculopathy, thoracolumbar region
  - M51.16 Intervertebral disc disorders with radiculopathy, lumbar region
  - M51.17 Intervertebral disc disorders with radiculopathy, lumbosacral region

M51.3 Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
  - M51.34 Other intervertebral disc degeneration, thoracic 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

ICD-10 requires to specify the presence of radiculopathy with disc degeneration. Disk degeneration with radiculopathy will be coded to disk disorder with radiculopathy.
Case Study – Herniation and Degeneration

Operative report

PREOPERATIVE DIAGNOSIS:
Lumbar radiculopathy, left, recurrent, chronic, severe.

POSTOPERATIVE DIAGNOSIS:
1. Disk herniation L3-S1, left, small.
2. Disk degeneration L3-S1, square.
3. Epidural fibrosis L3-S1, left, modest.

PROCEDURES:
1. Laminotomy/foraminotomy L5-S1, left.
2. Diskectomy L3-S1, left.
3. Spinal fusion L5-S1, intertransverse, bilateral.
4. Segmental instrumentation L5-S1, bilateral, with new/vasive
   Armada instrumentation.
5. Harvest right posterior iliac cancellous bone graft through a
   separate oblique incision.

DESCRIPTION OF PROCEDURE:
Anesthesia instituted. The patient turned to the prone position
on the Wilson frame. Final positioning performed. Back prepped
and draped in a sterile fashion. A midline incision fashioned
L1-S1, and a unilateral left-sided strip carried out. The
previous laminotomy was identified, expanded minimally cranially
and caudally. Caudal foraminotomy was performed. There was
modest epidural fibrosis, but no evidence of synovial cyst or
extruded disc fragment. The disc space was explored, noted to be
modestly protruding. The disc space was entered, and only a
minimal amount of degenerative material obtained.

It was elected to proceed with fusion L5-S1. Through a
sacrospinalis-splitting approach, the transverse processes of L5
and the sacral ala were exposed bilaterally and decorticated.
Under image intensifier control, new/vasive Armada instrumentation
applied at the base of the pedicles of L5 and S1 utilizing 6.5 mm
diameter screws of appropriate length.

Through an oblique incision over the posterior ilium, right,
cancellous bone graft harvested of excellent quality and
quantity. This was utilized to bridge the transverse process of
L5 to the sacral ala bilaterally. At this point, contoured rods
and retaining nuts were applied to the four pedicle screws, and
the nuts tightened to appropriate tension.

Prior to implantation of bone graft, the wound was copiously
irrigated with antibiotic solution.

The fascial incisions closed in standard fashion, as was
subcutaneous tissue, and the lumbar incision as well as the
incision over the right posterior ilium. Sterile dressings
applied. Patient tolerated procedure well, left the operating
room in excellent condition.

ICD-10 Documentation for herniation & degeneration:

- Specify the body part as cervical, cervicothoracic, lumbar etc.
- Specify presence of myelopathy, radiculopathy, radiculitis,
  neuritis etc.

ICD-10 has specific codes for lumbosacral disc displacement and
degeneration with radiculopathy that was not present in ICD-9.

Name | ICD-10 PCS coding | Medical and surgical | Lower joints | Fusion | Body part (Lumbosacral joint) | Approach (Open) | Device (Interbody fusion device) | Qualifier (Posterior approach posterior column)
--- | --- | --- | --- | --- | --- | --- | --- | ---
Spinal fusion | 0SG30A1 | 0 | S | G | 3 | 0 | A | 1

ICD-10 requires to specify the presence of radiculopathy with disc displacement and degeneration.
## Radiculopathy

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified</td>
<td>M51.14 Intervertebral disc disorders with radiculopathy, thoracic region</td>
</tr>
<tr>
<td></td>
<td>M51.15 Intervertebral disc disorders with radiculopathy, thoracolumbar region</td>
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<tr>
<td></td>
<td>M51.16 Intervertebral disc disorders with radiculopathy, lumbar region</td>
</tr>
<tr>
<td></td>
<td>M51.17 Intervertebral disc disorders with radiculopathy, lumbosacral region</td>
</tr>
<tr>
<td></td>
<td>M54.14 Radiculopathy, thoracic region</td>
</tr>
<tr>
<td></td>
<td>M54.15 Radiculopathy, thoracolumbar region</td>
</tr>
<tr>
<td></td>
<td>M54.16 Radiculopathy, lumbar region</td>
</tr>
<tr>
<td></td>
<td>M54.17 Radiculopathy, lumbosacral region</td>
</tr>
</tbody>
</table>
Case Study – Spinal Fusion

Operative report

PREOPERATIVE DIAGNOSIS:
1. Severe thoracic spondylolisthesis.
2. Thoracic disk disease, T11-T12.
3. Right thoracic radiculopathy.

POSTOPERATIVE DIAGNOSIS:
1. Severe thoracic spondylolisthesis.
2. Thoracic disk disease, T11-T12.
3. Right thoracic radiculopathy.

PROCEDURES PERFORMED:
1. Right-sided transthoracic anterior approach to the T11-T12 space.
2. T11-T12 discectomy.
3. T11-T12 implantation of intervertebral cage.
4. T11-T12 fusion.
5. Harvest of local autologous rib graft.
6. Intraoperative neurophysiological monitoring (Dr. Alex Ahmed).

DESCRIPTION OF PROCEDURE:
After obtaining informed consent, the patient was brought to the operating room, general anesthesia was induced. He was given Ancef, double lumen intubation was performed. The patient was placed in the lateral decubitus position with the right side up. Recombining electrodes were placed by Dr. Ahmed. There were no abnormalities noted at the conclusion of the case. The right side of the chest was prepped and draped in the usual sterile fashion. You refer to Dr. Tyner’s separately dictated operative report for details of the approach.

Once the Naasive minimally invasive retractor system was placed to expose the T11-T12 disk space, a large bridging anterior osteophyte correlating to the abnormalities noted on the CT was identified. The large osteophyte was carefully removed using rongeurs as well as the angiouch high-speed air drill. We then entered the disk space. There was a bridging osteophyte spanning the anterior portion of the T11-T12 disk space as well, which was similarly removed with the drill and Kerrison rongeurs. The disk space was completely cleared of the degenerative disk material and the endplates were prepared in preparation for fusion.

ICD-10 Documentation for Spinal Fusion:

- Specify the vertebral joint (occipital-cervical, cervical, cervicothoracic, lumbar, lumbosacral, thoracic, thoracolumbar
- Specify the number of joints fused
- Specify the type of fusion done (use of interbody fusion device, autologous tissue, non-autologous tissue, synthetic substitute
- Specify the levels involving fusion device (1, 2, 3.. joint levels)
- Specify approach (open, percutaneous, or percutaneous endoscopic)
- Specify the approach and column (anterior approach anterior column, posterior approach anterior column, or posterior approach posterior column)

M51.14 M51 – Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorder

1. With radiculopathy

M47.24 M47 – Spondylosis

2. With radiculopathy

ICD-10 requires to specify the vertebral joint, the type of fusion device used, the approach used and the column fused.
**Intervertebral Disc Disorders**

1) Document site as:
- Cervical
- Thoracic
- Lumbar
- Sacral

2) Document any associated:
- Myelopathy
- Radiculopathy
or
- Sciatica

**Pathological Fracture**

1) Specify whether etiology is:
- Age related or disuse osteopenia
- Neoplastic
or
- Some other disease

2) Document encounter as initial, subsequent with nonunion, subsequent with delayed healing

**Traumatic Fractures**

1) Document the specify vertebra involved
- First lumbar vertebra, First thoracic vertebra

2) Document open versus closed

3) Document Type of fractures, such as Burst, wedge compression

4) Document if stable or unstable

5) Document encounter as initial, subsequent with nonunion, subsequent with delayed healing

6) For sacral fractures, document:
- Zone I, II and III
and
- Minimally versus severely displaced
or
- Type 1, 2, 3, or 4

**Congenital deformity of spine**

1) Document type of deformity
- Hyperlordosis
- Kyphosis
- Scoliosis

2) Document the specific region:
- Cervical
- Lumbar
- Thoracic
- Cervicothoracic
- Thoracolumbar

**Spina bifida**

1) Document the specific region:
- Cervical
- Lumbar
- Cervicothoracic
- Thoracolumbar

2) Specify if spina bifida occulta, Arnold-Chiari syndrome, type II

3) List any associated paraplegia

4) Identify the presence of hydrocephalus.

**Spondylosis**

1) Document by type
- Anterior spinal artery compression syndrome
- Vertebral artery compression syndrome
- Other spondylosis
- with or without myelopathy and/or radiculopathy

2) Document site as:
- Occipito-atlanto-axial
- Cervical or Cervical-thoracic
- Thoracic or Thoracolumbar
- Lumbar or Lubmosacral
- Sacral or Sacrococcygeal
## Congenital Anomaly of the Spine

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>756.19 Other congenital anomaly of spine</td>
<td>Q76.411 congenital kyphosis, occipito-atlanto-axial region</td>
</tr>
<tr>
<td></td>
<td>Q76.412 congenital kyphosis, cervical region</td>
</tr>
<tr>
<td></td>
<td>Q76.413 congenital kyphosis, cervicothoracic region</td>
</tr>
<tr>
<td></td>
<td>Q76.414 congenital kyphosis, thoracic region</td>
</tr>
<tr>
<td></td>
<td>Q76.415 congenital kyphosis, thoracolumbar region</td>
</tr>
<tr>
<td></td>
<td>Q76.419 congenital kyphosis, unspecified region</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>724.5 Congenital musculoskeletal deformity of spine</td>
<td>Q76.3 Congenital scoliosis due to congenital bony malformation</td>
</tr>
<tr>
<td></td>
<td>Q76.425 Congenital lordosis, thoracolumbar region</td>
</tr>
<tr>
<td></td>
<td>Q76.426 Congenital lordosis, lumbar region</td>
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<tr>
<td></td>
<td>Q76.427 Congenital lordosis, lumbosacral region</td>
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<tr>
<td></td>
<td>Q76.428 Congenital lordosis, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td></td>
<td>Q76.429 Congenital lordosis, unspecified region</td>
</tr>
<tr>
<td>Procedure</td>
<td>Body section</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Spinal fusion</td>
<td>Document body section: Cervical, thoracic, lumbar Cervicothoracic</td>
</tr>
<tr>
<td>Biopsy</td>
<td>Document: Extraction or drainage (spinal tap)</td>
</tr>
<tr>
<td>Diskectomy</td>
<td>Document: Excision or resection</td>
</tr>
<tr>
<td>Injection</td>
<td>Document body part as: Epidural space or spinal canal</td>
</tr>
</tbody>
</table>
Acuity: acute, chronic, intermittent

Severity: mild, moderate, severe

Etiology: trauma, diabetes, renal failure, exercise or infection induced

Location: where is it? Be specific about which joint, chest, femur, posterior thorax

Laterality: which side is it? Left, right, both?

Detail: Present on admission status, associated symptoms (hypoxia, loss of consciousness), additional medical diagnoses, initial versus subsequent encounter
IT'S NEVER TOO LATE!

NiceFun.net

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For any questions:

QUESTIONS? CONCERNS?

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