Diabetic Foot Ulcer - Case #1

Physician Report

EXAM: X-ray Left foot, Three Views

COMPARISON: None available.

HISTORY: Diabetic foot ulcer.

FINDINGS: The actual ulcer is not marked. There is no abnormal periosteal reaction or bony destructive lesion and the bones and joints are remarkable only for a somewhat flattened arch of the foot.

CONCLUSION: No acute bony finding. If further evaluation is needed or there is a continuing suspicion of osteomyelitis, some follow-up films or further evaluation with MRI might be considered.

Coding Summary

	ICD-9	ICD-10
Primary Dx	250.80 - Diabetes with other specified manifestations, type II or unspecified type, not state as uncontrolled 707.15 - Ulcer of other part of the foot	E11.621 - Type 2 diabetes mellitus with foot ulcer L97.529 - Non-pressure chronic ulcer of other part of left foot with unspecified severity

ICD-10 Guidance

4 potential ICD-10 codes exist under E11 - Type 2 diabetes with skin complications.

- Laterality (left)
- Location (foot)
- Diabetes type (default to type 2)
- Ulcer severity (not specified)

Leg Pain - Case #2

Physician Report

EXAM: Lumbar Myelogram using Fluoroscopic Guidance

FLUORO TIME: 0.16 minutes

CONTRAST: 12 cc Isovue-M 200 intrathecal

HISTORY: Bilateral leg pain, left greater than right.

TECHNIQUE: After obtaining written informed consent, the overlying skin was prepped and draped in usual sterile fashion. Local anesthesia was given with 1% lidocaine. L3 interlaminar space was used for access.
There is bilateral subarticular recess stenosis at L4-L5. Fusion is seen at L5-S1.
The patient tolerated the procedure well.

Please see CT scan performed same day for further assessment.

Coding Summary

	ICD-9	ICD-10
Primary Dx	729.5 - Pain in limb	M79.604 - Pain in right leg M79.605 - Pain in left leg

ICD-10 Guidance

7 potential ICD-10 codes exist under M79 - Pain in limb, hand, foot, fingers and toes.

- Location (leg)
- Laterality (left and right)

Swelling - Case #3

Physician Report

EXAM: Ultrasound Venous Duplex

HISTORY: Right lower extremity swelling. Assess for DVT.

B-mode, gray scale and spectral analysis was performed on the right lower extremity

FINDINGS: Normal compressibility, respiratory phasicity, and augmentation is demonstrated throughout the deep venous system of the right lower extremity.

IMPRESSION: No sonographic evidence for deep venous thrombosis of the right lower extremity.

Coding Summary

	ICD-9	ICD-10
Primary Dx	729.81 - Swelling of limb	M79.89 - Other specified soft tissue disorder

ICD-10 Guidance

2 potential ICD-10 codes exist under M79 - Other specified soft tissue disorders

- There is not a specific code for swelling of limb in ICD-10

Shoulder Bursitis - Case #4

Physician Report

EXAM: Left Shoulder Arthrogram Under Fluoroscopic Guidance

COMPARISON: None.

HISTORY: Football injury last fall with continued pain with working out with weights currently.

ARTHROGRAM:
One minute and 1 second of fluoroscopy time was utilized for this procedure.

TECHNIQUE AND FINDINGS:
After informed consent was obtained, the area overlying the anterior aspect of the left shoulder was prepped and draped in sterile fashion and anesthetized with 1 cc of 1% lidocaine into the subcutaneous and deeper tissues. A 20-gauge spinal needle was placed into the joint from an anterior approach with intraarticular administration of a total of 14 cc of Omnipaque 240 containing a 200:1 dilution of Omniscan. A total of 0.1 cc Omniscan was utilized for this procedure. The patient tolerated the procedure well and there are no immediate complications. Note is made of prominent subcoracoid bursitis.

IMPRESSION: Subcoracoid bursitis.

Coding Summary

	ICD-9	ICD-10
Primary Dx	726.19 - Other specified disorders of rotator cuff syndrome of shoulder and allied disorders	M75.52 - Bursitis of left shoulder

ICD-10 Guidance

3 potential ICD-10 codes exist under M75 - Bursitis of the shoulder.

- Location (shoulder)
- Laterality (left)