Hip Subluxation - Case #1

Physician Report

LOCATION: OP
EXAM: Left hip 2 views

CLINICAL HISTORY: Left hip pain.

FINDINGS: The patient appears to be skeletally immature. There is irregularity of the lateral margin of the left femoral head; valgus angulation of the left proximal femur is seen. The left acetabulum is shallow; there is mild superolateral subluxation of the left femoral head relative to the acetabulum. No fracture frank dislocation or destructive lesion is seen.

IMPRESSIONS: No fracture identified. The left acetabulum is shallow and there is mild superolateral subluxation of the left femoral head relative to the acetabular cup.

Coding Summary

	ICD-9	ICD-10
Primary Dx	835.00 - Closed dislocation of hip, unspecified site	S73.032A - Other anterior subluxation of left hip, initial encounter

ICD-10 Guidance

6 potential ICD-10 codes exist under S73 - Other anterior dislocation of hip.

- Location of injury (femoral head)
- Sub location of injury (superolateral)
- Laterality (left)
- Type of injury (subluxation)
- Episode of care (clinical history)

Finger Dislocation - Case #2

Physician Report

LOCATION: OP
EXAM: Right Finger X-ray, 2 views

CLINICAL HISTORY: Post reduction of dislocation

FINDINGS: Comparison is made to prior study done at 9:16 p.m. There has been successful reduction of the dislocated third PIP joint, middle phalanx. There is mild soft tissue swelling of the digit. There is a question of a tiny 4 mm chip fracture at the base of the middle phalanx. No radiopaque foreign body.

IMPRESSION: Successful reduction of the dislocation. Questionable tiny chip fracture at the PIP joint.

Coding Summary

	ICD-9	ICD-10
Primary Dx	834.02 - Closed dislocation of interphalangeal (joint), hand	S63.292A - Dislocation of distal interphalangeal joint of right middle finger, initial encounter

ICD-10 Guidance

78 potential ICD-10 codes exist under S63 - Dislocation of the finger.

- Location of injury (middle finger)
- Sub location of injury (distal interphalangeal joint)
- Laterality (right)
- Type of injury (dislocation)
- Episode of care (clinical history)

Knee Sprain - Case #3

Physician Report

LOCATION: OP
EXAM: MR right knee without contrast.

CLINICAL HISTORY: ACL sprain, knee pain.

TECHNIQUE: Sequences are obtained of the right knee without contrast in multiple orthogonal planes.

FINDINGS:
Menisci: The medial and lateral menisci are within normal limits without evidence of tear.
Ligaments and tendons: Mild diffusely increased signal within the anterior cruciate ligament suggests grade 1 sprain. The posterior cruciate ligament is intact. No abnormalities noted of the medial or lateral collateral ligaments. The quadriceps and patellar tendons are normal in appearance.
Joint space: No joint effusion evident. The patellar cartilage is within normal limits without evidence of chondromalacia.
Skeletal structures and soft tissues: The skeletal structures are within normal limits. No abnormalities noted of the surrounding musculature or soft tissues.

IMPRESSION: Grade 1 sprain of the anterior cruciate ligament.

Coding Summary

	ICD-9	ICD-10
Primary Dx	844.2 - Sprains and strains of knee and leg, Cruciate ligament of knee	S83.511A - Sprain of anterior cruciate ligament of right knee, initial encounter

ICD-10 Guidance

9 potential ICD-10 codes exist under S83 - Sprain of knee.

- Location of injury (knee)
- Sub location of injury (anterior cruciate ligament)
- Laterality (right)
- Type of injury (sprain)
- Episode of care (clinical history)

Head Contusion - Case #4

Physician Report

LOCATION: ED
EXAM: CT of the brain, without contrast

CLINICAL HISTORY: Seizures, head injury.

COMPARISON: None.

TECHNIQUE: Routine unenhanced axial imaging of the brain was performed.

FINDINGS: There is no acute intracranial hemorrhage or extra-axial collection. There is no hydrocephalus, midline shift, or space occupying mass. Gray-white matter differentiation is well preserved with no definite CT evidence of an acute infarct. There is a large left frontal scalp hematoma. The cranial vault and skull base are intact. The paranasal sinuses and mastoid air cells are pneumatized and well aerated.

IMPRESSION: Large left frontal scalp hematoma with no underlying fracture and no acute intracranial abnormality.

Coding Summary

	ICD-9	ICD-10
Primary Dx	920 - Contusion of face, scalp, and neck except eye(s)	S00.03XA - Contusion of scalp, initial encounter

ICD-10 Guidance

12 potential ICD-10 codes exist under S00 - Contusion of the head.

- Location of injury (head)
- Sub location of injury (scalp)
- Type of injury (contusion)
- Episode of care (ED location and clinical history)