DEXA - Case #1

Physician Report

LOCATION: OP
EXAM: DEXA

CLINICAL HISTORY: Osteoporosis, postmenopausal

TECHNIQUE: Bone densitometry was performed using the Hologic Discovery W DXA scanner.

AP spine (L1-L4); BMD: 0.728 g /cc, a 0.3% decrease in density; T score: -2.9; Z score: 0.3
WHO classification: Osteoporosis

Left femoral neck: BMD: 0.674 g/cc; T score: -1.7; Z score: 0.5
WHO classification: Osteopenia

Left total hip: BMD: 0.745 g/cc, a 4.2% decrease in density; T score: -1.6; Z score: 0.3
WHO classification: Osteopenia

Right femoral neck: BMD: 0.670 g/cc; T score: -1.7; Z score: 0.5
WHO classification: Osteopenia

Right total hip: BMD: 0.724 g/cc, an 11.4% decrease in density; T score: -1.8; Z score: 0.2
WHO classification: Osteopenia

Impression: Osteoporosis with increased fracture risk.

Coding Summary

	ICD-9	ICD-10
Primary Dx	733.01 - Senile osteoporosis	M81.0 - Age-related osteoporosis without current pathological fracture

ICD-10 Guidance

4 potential ICD-10 codes exist under M81 - Age- related osteoporosis

- Type (postmenopausal)

Osteoporosis with Fracture - Case #2

Physician Report

LOCATION: IP
EXAM: Kyphoplasty of L1 and L3 vertebral bodies

CLINICAL HISTORY: 84 female patient with acute, painful osteoporotic compression fractures at L1 and L3, as demonstrated on recent MRI, refractory to conservative measures. Osteoporosis as demonstrated on recent bone density examination.

PROCEDURE: Written informed consent was obtained. The patient was brought to the fluoroscopy suite and placed prone. Anesthesia service provided monitored anesthesia care. The lumbar area was sterilely prepped and draped. All elements of maximal sterile technique were employed. 1 g of Ancef was given intravenously. The L1 and L3 vertebral bodies were localized under fluoroscopy. Placement of the left-sided transpedicular cannulas was performed first. The skin, soft tissue tract, and periosteum over the left pedicle at both levels were anesthetized with 1% lidocaine and 0.25% Marcaine. Subsequently, an 11-gauge bone needle was advanced from a posterior, extra pedicular route into the central portion of the L1 and L3 vertebral bodies. Next, the needles was exchanged over a J-wire for a 9-gauge working cannula. Next, a directional bone drill was advanced through the cannulas to the proximal third of the vertebral body and across midline within both vertebral bodies under direct fluoroscopic guidance. Subsequently, a tiny 7 mm in diameter by 20 cm long cavity was created with the drill device at both levels. Next, a shield device was deployed through the cannula, within the cavity within the vertebral body under fluoroscopic guidance. Next, polymathic methacrylate was injected through the working cannulas and into the shields deployed within the vertebral bodies under direct fluoroscopic visualization. Small mild paravertebral extravasation was noted to the patients left. Both cannulas were removed. The incision site sites were closed with subcuticular 4-0 Vicryl, Dermabond and Steri-Strips. The patient tolerated the procedure well and there was no immediate complication. Approximate fluoroscopy time was 10 minutes.

IMPRESSION: Successful L1 and L3 kyphoplasty utilizing shield implants and bone cement.

Coding Summary

	ICD-9	ICD-10
Primary Dx	733.13 - Pathologic fracture of vertebrae 733.01 - Senile osteoporosis	M80.08XA - Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture

ICD-10 Guidance

6 potential ICD-10 codes exist under M80 - Age-related osteoporosis with fracture

- Type (age-related)
- Fracture location (vertebral)
- Episode of care (clinical history and current procedure)

Radiculopathy - Case #3

Physician Report

LOCATION: OP
EXAM: MRI lumbar spine without contrast

CLINICAL HISTORY: Lumbosacral radiculopathy

Technique: Multiplanar multisequence MR imaging of the lumbar spine was performed without contrast. No prior study is available for comparison.

Findings: There is approximately 20 degrees of apex leftward curvature centered at L2/L3. Lumbar vertebral height and marrow signal are preserved throughout. 5 lumbar segments are assumed. The conus terminates normally at L1. The paraspinal soft tissues are unremarkable. Intervertebral changes are noted as follows:
L1/L2: Normal
L2/L3: Normal
L3/L4: Normal
L4/L5: Mild, 2 millimeter broad-based posterior disc protrusion with mild facet arthropathy ligamentum flavum hypertrophy. No significant central canal or foraminal stenosis.
L5/S1: Mild, 2 mm broad-based posterior disc protrusion encroaching upon the traversing bilateral S1 nerve roots within the lateral recesses. There is mild hypertrophic facet arthropathy, as well. There is no significant foraminal stenosis.

IMPRESSION: Mild disc protrusion at L5/S1 encroaches upon the traversing S1 nerve roots.

Coding Summary

	ICD-9	ICD-10
Primary Dx	722.10 - Displacement of lumbar intervertebral disc without myelopathy 724.4 - Thoracic or lumbosacral neuritis or radiculitis, unspecified	M51.17 - Intervertebral disc disorders with radiculopathy, lumbosacral region

ICD-10 Guidance

9 potential ICD-10 codes exist under M51 - Intervertebral disc disorders with radiculopathy

- Type (protrusion)
- Location (lumbosacral)
- Status (radiculopathy)