

Plantar Plate Repair, Coding Sequela, and Other Topics

Here are the answers to some commonly-asked questions.

BY HARRY GOLDSMITH, DPM

Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

Plantar Plate Repair

"What would be the best diagnosis code to use for a plantar plate tear? And what would be the CPT code for a primary repair of a plantar plate tear?"

There is no specific CPT or ICD-10 code for a plantar plate tear. If the procedure you perform was designed to repair the position and instability of the toe with repair of the metatarsal-phalangeal joint capsule/ligament (one would presume that is why you are there), then CPT 28313 (reconstruction, angular deformity of toe, soft tissue procedures only) is appropriate.

ICD-10 coding isn't quite as easy. The code you choose will depend on your diagnosis (based on finding preand intra-op) and the etiology. Some likely coding candidates include:

Sprain of metatarsophalangeal joint of right great toe: S93.521 plus a 7th character (A, D, S)

Sprain of metatarsophalangeal joint of left great toe: S93.522 plus a 7th character (A, D, S)

Sprain of metatarsophalangeal joint of right lesser toe: \$93.524 plus

a 7th character (A, D, S)

Sprain of metatarsophalangeal joint of left lesser toe: S93.525 plus a 7th character (A, D, S)

These code choices presume injury, such as laceration or traumatic tear of cartilage, joint, or ligament of metatarsophalangeal joint.

Disorder of ligament, left foot— M24.275

With the "M" ICD-10 codes, if there are symptoms present with the deformity(ies) add the appropriate symptom ICD-10 code. For example:

Pain in right foot—M79.671 Pain in left foot—M79.672

There is no specific CPT or ICD-10 code for a plantar plate tear.

If the etiology is a spontaneous rupture of the plantar plate, consider using:

Other articular cartilage disorders, right foot M24.174

Other articular cartilage disorders, left foot M24.175

Note: When there is no option of "toe" ICD-10 codes in a subcategory that lists ankle and foot, foot codes would include toe diagnoses/conditions.

If the finding is instability of the joint or ligamentous laxity secondary to a traumatic or spontaneous rupture of the plantar plate, consider adding:

Disorder of ligament, right foot— M24.274 Pain in right toe(s)—M79.674 Pain in left toe(s)—M79.675

Seguela

Actually, coding "sequela" in ICD-10 is not all that difficult. There are, however, two issues that seem to always come up when discussing sequela 7th character use. First, how "deep" into my history-taking do I need to go in order to determine that the presenting complaint is the result of an old injury?; and second, why bother [specifically in the coding]? Those are very common and fair questions to ask. When a patient presents with pain in the left ankle, the typical history of present illness (HPI) questions (location, quality, severity, duration, timing, context,

Continued on page 50

Plantar Plate (from page 49)

modifying factors, and associated signs and symptoms) do not necessarily lend themselves to capturing information regarding a previous injury to the same site. The closest HPI element would be "context" (example: tripped stepping off a curb). The problem is that most patients, when asked about any injury, have problems recalling specifics unless

the diagnosis. If, after examining the patient and reviewing x-rays, you are able to make the diagnosis of degenerative joint disease, left ankle, you now have to whittle down the coding from these options:

- M08.07—(arthritis [juvenile rheumatoid arthritis], unspecified, ankle and foot)
- M14.67—(arthritis [neuropathic], ankle and foot)
 - M19.17—(arthritis [post-trau-

Coding sequela is a two-step process.

the injury was recent. Most doctors aren't just satisfied with when the latest bout of pain began, and do try to elicit information on any possible injury. Unfortunately, some patients fail to connect the dots regarding their present complaint and an old injury; some patients forget the original injury (if it occurred months or years ago) and instead dwell on the episodes of pain or limitations.

So, that brings up a question frequently asked when discussing sequela, and that is, to what level of detail am I obligated to press the patient in order to get historical details and be able to correctly code for a sequela? Since sequela coding only pertains to current latent symptoms and/or limitations due to a previous injury or illness (NOTE: surgical complications are not coded under sequela), if the patient is unaware of the injury details necessary to correctly code (e.g., lateral non-displaced closed fracture of the distal fibula), do I need to request old records in order to accurately bill? The answer is, I don't know. I would say that if the information is readily available, you should use it to code the sequela. And I'll leave it at that.

So, how do you code a sequela?

Coding sequela is easy. It is a two-step process. Step #1: The first code (primary code) is the reason the patient made the appointment. In other words, take the chief complaint (e.g., my left ankle is painful), examine the patient, and come up with

matic], ankle and foot)

- M06.87—(arthritis [rheumatoid], ankle and foot)
- M00.87—(arthritis, due to other bacterial infection, ankle and foot)
- M00.17—(arthritis, due to Pneumococcal infection, ankle and foot)
- M02.37—(arthritis, due to Reiter's disease, ankle and foot)
- M00.07—(arthritis, due to Staphylococcal infection, ankle and foot)
- M00.27—(arthritis, due to Streptococcal infection, ankle and foot)
- M19.27—(arthritis, localized, secondary, ankle and foot).

patient four years previously had fractured the same ankle, and comfortably tie that to the reason the patient is in your office (osteoarthritic changes to the left ankle, post-traumatic), you have the second diagnosis—the old injury. Obviously, you will need to know either from information relayed to you by the patient or from old records what the specific diagnosis of the time was (e.g., lateral non-displaced closed fracture of the distal fibula, left) in order to accurately code it. In this case, the old diagnosis was S82.65x- (which requires a 7th character). You are given 16 7th character options, but the only one you are interested in is "S" (sequela). Code it S82.65xS. And you have your second code.

Your billing would be:

M19.172 (post-traumatic osteoarthritis, left ankle and foot)

S82.65xS (lateral non-displaced closed fracture of the distal fibula, left; sequela)

Begging the questions:

1) Won't I get paid if I just list M19.172 on the claim?

Response: Probably. The point, however, is that like in your medical record documentation, you are

When you see a hyphen (-) at the end of an ICD-10 code, it indicates that you need additional characters to "complete" the code and make it a valid code.

A couple of probing questions (e.g., did you ever injure that ankle? See Step #2 below) should get you down to the most likely diagnosis... which will be then be your primary diagnosis. Only code the presenting symptom (i.e., pain) if you cannot make a specific diagnosis.

Step #2: If you can discern the cause/etiology of the complaint (primary diagnosis), you code it second. For example, in the case of the patient with the painful left ankle that you diagnose as arthritic changes (degenerative joint disease, osteoarthritis), if in the course of your history-taking, you find out that the

expected to be as specific as you reasonably can in your diagnosis coding. Specificity in your service and procedure coding goes without question.

2) What's with the hyphen (dash) at the end of a code?

Response: When you see a hyphen (-) at the end of an ICD-10 code, it indicates that you need additional characters to "complete" the code and make it a valid code.

3) I can't help but notice the lower case "x" in S82.65xS. Why is it in lower case?

Continued on page 51

CODINGLINE PARTICULARS

Plantar Plate (from page 50)

Response: The base code is S82.65 with indicator noting that it needs a 7th character. There is no listed 6th character, just that to be a valid code there needs to be 7 characters. To fill in the missing character (we know what the 7th character will be an "S", but there is no 6th character option), we use the "x" in the 6th character position to give us S82.65xS. Then "x" represents a placeholder (AKA "dummy placeholder" or "x" placeholder) for "future expansion". The answer to the question of "x" being lower case is easy: it is my preference to use a lower case "x". Both lower case and capital "X"s are acceptable.

4) In the list of all my arthritis choices, what if I were to pick M19.272 (arthritis, localized, secondary, left ankle and foot) instead of M19.172 (post-traumatic osteoarthri-

.....

tis, left ankle and foot)? Would I still be paid?

Response: Probably, but that's not the point. If the accurate diagnosis is arthritis, localized secondary, left ankle, then that's the diagnosis you document in the medical record and list on your claim form.

5) If I didn't see in a past record whether the fracture of the lateral malleolus was open or closed, or displaced or non-displaced, what am I supposed to do?

Response: ICD-10 guidelines do help in this case: if the previous or your current medical records fail to note whether the fracture is open or closed, it is presumed to be closed. If the previous or your current medical records fail to note whether the fracture is displaced or non-displaced, it is presumed to be displaced. The former makes sense; the latter is bizarre...but those are the guidelines. **PM**

DISCLAIMER: The information offered by CodinglinePARTICULARS is provided in good faith for purposes of communication and discussion, and is strictly the opinion of the editor, Harry Goldsmith, DPM, or the listed authors. Neither Codingline nor Podiatry Management represents that any such opinion is either accurate or complete, and should not be relied upon as such. The reader is responsible for ensuring correct applicability of any information, opinion, or statements written in by CodinglinePAR-TICULARS. Specific payer reimbursement information should be obtained from the specific payer in question.



Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the *Podiatry Management* Lifetime Achievement Award.