Managing Your Practice

Going After Orthopaedic Aftercare

Reporting diagnosis codes for orthopaedic aftercare

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The provision of orthopaedic aftercare falls into two categories, which are addressed differently under the International Classification of Diseases, 10th revision (ICD-10). One category of aftercare uses codes beginning with the letter “Z”; the other category of aftercare uses the 7th character extension.

Z aftercare codes are used in office follow-up situations in which the initial treatment of a disease is complete and the patient requires continued care during the healing or recovery phase or for long-term consequences of the disease. They should not be used to describe the aftercare of traumatic injuries or fractures. In those situations, the 7th character extension should be used because it provides specific information about the healing phase and subsequent care. (For an overview of the 7th character extensions used to describe the phase of treatment of traumatic injuries, see “When 7 Isn’t a Lucky Number,” AAOS Now, November 2014.)

This article focuses on code category Z47, which is used to report orthopaedic aftercare following treatment for a condition or disease, excluding aftercare associated with healing fractures or traumatic injuries.

Joint replacement

Code Z47.1 (aftercare following joint replacement surgery) is used during the follow-up phase of any joint replacement surgery, even if the replacement was for treatment of a fracture. It must be accompanied by a code from subcategory Z96.6, which identifies the specific joint location and laterality (Table 1).

For example, a patient who had a right total hip arthroplasty (THA) surgery for severe OA, who is asymptomatic with a normal gait, a nicely healed wound, and no signs of loosening, subsidence, or wear. Coding for this visit would be as follows:
- Z09—Encounter for follow-up examination for conditions other than malignant neoplasm
- Z96.641—Presence of right artificial hip joint

This second example uses Z96.6, which indicates surveillance following completed treatment of a disease, condition, or injury. Its use implies that the condition has been fully treated and no longer exists. Z96 would be used for all annual follow-up exams, provided no complications or symptoms are present. If abnormal pain, inflammation, infection, dislocation, or other mechanical problem is found, the complication code would be reported. Normal postoperative pain or the “slight limp” described in the first example is not assigned an ICD-10 diagnosis code because it is considered routine healing.

The diagnosis of primary OA of the right hip is no longer reported because the patient no longer has the condition at that location. If other body areas were evaluated for symptomatic OA on this visit, a diagnosis code would be assigned and the documentation would reflect the evaluation and examination of those areas.

As can be seen in Table 1, no specific code exists for toe joint arthroplasty. If a toe joint is replaced, the “other” code (Z96.698) would be reported. Notice that this code does not specify laterality.

Another example would be the patient seen 1 year following THA surgery for severe OA, who is asymptomatic with a normal gait, a nicely healed wound, and no signs of loosening, subsidence, or wear. Coding for this visit would be as follows:
- Z09—Encounter for follow-up examination for conditions other than malignant neoplasm
- Z96.641—Presence of right artificial hip joint

Three joint locations (hip, knee, and finger) have bilateral codes. All other joint locations (elbow, wrist) in which bilateral implants are present must be reported with two codes, one for the right and one for the left joint.

Internal fixation device removal

Code Z47.2 (encounter for removal of internal fixation device) is reported when asymptomatic hardware, used initially to treat a condition that was not an injury or fracture, is removed following completed treatment. This code may not be used very often, because asymptomatic hardware is rarely removed.

If a problem with internal fixation exists, one of the following hardware complication codes would be reported:
- T84.84—Pain due to internal orthopaedic prosthetic devices, implants, and grafts
- T84.1 or T84.2—Mechanical complication of internal fixation of limb including breakdown, displacement, or other mechanical complication
- T84.6—Infection and inflammatory reaction due to internal fixation device

These complication codes can be found in the Injury chapter. When they are used, the 7th character extension is used to report aftercare. ICD-10 guidelines instruct users not to report code Z47.2 in the following situations:
- Adjustment of internal fixation for fracture treatment (use fracture code with 7th character extension indicating routine healing)
- Removal of internal or external fixator when used to treat a fracture or injury (use fracture code with 7th character extension indicating routine healing)

The following three codes are used in staged joint revisions for aftercare following the removal of the prosthesis and as the operative diagnosis when the second stage (reimplantation) is performed:
- Z47.31—Following explantation of shoulder joint prosthesis
- Z47.32—Following explantation of hip joint prosthesis
- Z47.33—Following explantation of knee joint prosthesis

Note that specific codes are used only for the knee, hip, and shoulder; any other joint locations would be reported with code Z47.89 (encounter for other orthopaedic aftercare).

For specific items on reporting the ICD-10 codes for staged joint revision surgery, see “Clean Up Diagnosis Coding for Staged Revisions,” AAOS Now, July 2015.

Surgical amputations and scoliosis

Codes for aftercare following surgical amputation and aftercare following scoliosis surgery are new categories in ICD-10-CM.

Code Z47.81 (encounter for orthopaedic aftercare following surgical amputation) is used for visits following a surgical amputation and must be accompanied by an additional code that identifies the amputated limb (Table 2). This is not the diagnosis code used to identify the reason (gangrene, tumor, infection, or trauma) for the amputation, but should be used for the care provided after the amputation.

Code Z47.82 (encounter for aftercare following scoliosis surgery) is specific to scoliosis surgery. Like total joint replacements, complications would be reported with the codes listed previously for pain, mechanical complications, or infection.

For other orthopaedic aftercare following the active treatment of a disease, deformity, or condition that is not the result of an injury, use Z47.89 (encounter for other orthopaedic aftercare). For example, this code would be used for a follow-up visit by a 67-year-old man who underwent...