ICD-10-CM Compliance White Paper

Whether you are at the early stages or in the home stretch of ICD-10 implementations, here are some strategies to help you be prepared.

Background

What is ICD-10?

The World Health Organization's (WHO) International Classification of Diseases has served the healthcare community for over a century. The United States implemented the current version (ICD-9) in 1979. While most industrialized countries moved to ICD-10 a number of years ago, the United States is just now transitioning to ICD-10 with an anticipated final compliance date of October 1, 2015. ICD-10 is a classification system for diagnosis codes only. The system does not contain a procedural code set. The U.S. is adopting a modified version of ICD-10 known as ICD-10-CM. Any references to "ICD-10" throughout this paper refers to ICD-10-CM.

ICD-10 provides greater specificity in coding injuries than ICD-9. While many of the coding guidelines for injuries remain the same in ICD-9, ICD-10 does include some new features, such as seventh character extensions and the concept of reporting laterality.

In ICD-10, injuries are grouped by body part rather than by category, so all injuries of a specific site (such as head and neck) are grouped together rather than groupings of all fractures or all open wounds. Categories grouped by injury in ICD-9 such as fractures (800–829), dislocations (830–839), and sprains and strains (840–848) are grouped in ICD-10 by site, such as injuries to the head (S00–S09), injuries to the neck (S10–S19), and injuries to the thorax (S20–S29). Success with coding under ICD-10 will hinge largely on provider's documentation being complete.

There are 22 chapters in ICD-10. Orthopaedic surgeons and orthopaedic coders will commonly use:

- Chapter 13 – Diseases of the Musculoskeletal and Connective Tissue
- Chapter 17 – Congenital Malformations, Deformations and Chromosomal Abnormalities
- Chapter 19 – Injuries, Poisoning, and Certain Other Consequences of External Cause

For a free copy of the 2015 ICD-10-CM codes, click here.

Why does the US need to replace ICD-9?

Developed in the 1970s, the ICD-9 code set no longer fits with the needs of the 21st century healthcare system. ICD-10 will improve national healthcare initiatives such as Meaningful Use, value-based purchasing, payment reform and quality reporting. Without ICD-10 data, there will be serious gaps in the ability to extract important patient health information needed to support research and public health reporting, and move to a payment system based on quality and outcomes.

Who has to comply with ICD-10?

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims.

All payors are covered by HIPAA with the exception of Workers' Compensation and property and casualty, and auto insurers. This means that these other payors are also required to implement ICD-10 by October 1, 2015. In California, the Division of Workers' Compensation has announced that they will be following the CMS lead and requiring Workers' Compensation carriers/providers to implement ICD-10 as of October 1, 2015. It is expected that auto insurers will also follow suit.

ICD-10 will apply to dates of service of October 1, 2015 and after.

CMS announced that they will reimburse for wrongly coded claims for as long as one year after October 1, 2015 as long as the code billed is in the same broad family of codes as the correct ICD-10 code. This will help with claims processing and payment during this transitionary period.

Will ICD-10-PCS procedure codes be used for both inpatient and outpatient hospital services?

ICD-10-PCS procedure codes are designed only for hospital reporting of inpatient procedural services. Current Procedural Terminology (CPT) codes will continue to be used for physician and outpatient services.

ICD-10 seems so complicated. Do physicians really need to use all the codes?

No one healthcare provider will not use all the codes in the classification system; rather they will use a subset of codes based on their practice. Physicians will only use the ICD-10 code set for diagnosis coding. The ICD-10 code set is like a dictionary that has thousands of words, but individuals use some words very commonly while other words are never used.

Orthopaedic Coding Issues

The coding in ICD-10 will be much more specific for orthopaedic conditions, especially fractures. ICD-10 coding includes as many as seven characters.

- First 3 characters – Identify the category
- Next 3 characters – Note the etiology, anatomic site, or severity
- The last character – Will range from the letter A to S and note whether:
    - The Visit was Initial or Subsequent or due to Sequela
    - The Fracture was Closed or Open
    - The Healing was Routine, Delayed, a Malunion, or a Nonunion

In addition, in the case of open fractures, you must specify whether it is a Gustilo I, II, or III.

To improve your documentation, the American Health Information Management Association (AHIMA) has developed ICD-10 Documentation Tips which can be found at:
http://www.coa.org/docs/ahimadocumentationtips2.pdf

Several tips address orthopaedic conditions such as:

- Amputations
- Congenital Foot Deformities
- Debridement
- Dislocations
- Fractures (open and closed)
- Gustilo Classifications
- Hand and/or foot problems
- Lacerations
- Pain in the joint
- Scoliosis
- Soft tissue injuries
- Spinal Fusion
- Surgical complications
- Systemic infection/inflammation
- Tendon disorders

These Documentation Tips can form the basis of your patient encounter forms.

	Chart of 7th Digit Characters
A.	Initial Encounter for Closed Fracture
B.	Initial Encounter for Open Fracture Type I or II; Initial Encounter for Open Fracture NOS
C.	Initial encounter for Open Fracture Type IIIA, IIIB, or IIIC
D.	Subsequent encounter for Closed Fracture with routine healing
E.	Subsequent encounter for Open Fracture Type I or II with routine healing with routine healing
F.	Subsequent encounter for Open Fracture Type IIIA, IIIB, or IIIC with routine healing
G.	Subsequent encounter for Closed Fracture with delayed healing
H.	Subsequent encounter for Open Fracture Type I or II with delayed healing
I.	(not used)
J.	Subsequent encounter for Open Fracture Type IIIA, IIIB, or IIIC with delayed healing
K.	Subsequent encounter for Closed Fracture with nonunion
L.	(not used)
M.	Subsequent encounter for Open Fracture Type I or II with nonunion
N.	Subsequent encounter for Open Fracture Type IIIA, IIIB, IIIC with nonunion
O.	(not used)
P.	Subsequent encounter for Closed Fracture with malunion
Q.	Subsequent encounter for Open Fracture Type I or II with malunion

R.	Subsequent encounter for Open Fracture Type IIIA, IIIB, or IIIC with malunion
S.	Sequela – Cause of current illness or injury

What are some differences and similarities between ICD-9 and ICD-10?

1) In ICD-9 many orthopaedic codes begin with the number 7 or 8.
2) ICD-9, codes beginning with the number 7 are found in Chapter 13 and range from 710-739. In ICD-10, most of those same diagnoses are still found in Chapter 13, the chapter has the same name, but the codes will range from M00 to M99.
3) Codes for osteoarthritis of the knee, pain in the hip, and degenerative meniscus all begin with the number 7 in ICD-9. Those same conditions, when not the result of an acute injury, will be found in the musculoskeletal chapter in ICD-10, but will begin instead with the letter "M."
4) In ICD-9, acute injuries are found in the "Injury" chapter and begin with the number 8. In ICD-10, those same diagnosis will still be found in the "Injury" chapter, but will begin with the letter "S." These include tear of the anterior cruciate ligament, acute meniscal injury, SLAP lesion, hip fracture without osteoporosis, and all other traumatic fractures.
5) Pathologic and fragility fractures, however, will be found in the Chapter 13 in ICD-10 and will begin with the letter "M."
6) In ICD-10, a single code is used to report both the exact location of the pathologic fracture and the cause (age- or drug-induced, neoplasm, or other)

Table A compares the initial character(s) in ICD-9 and ICD-10 of codes of interest to orthopaedic practices. Click here. There will be some exceptions.
Table B – 2014 CMS 1500 form
Table C – Orthopaedic Coding Examples

CMS has developed a tool called the General Equivalency Map (GEMS) to help with the crosswalk from ICD-9 to ICD-10. This tool is not a substitute for learning ICD-10. GEMS should not be used to code patient encounters. GEMS is a tool that you can use to help convert data from ICD-9 to ICD-10 and vice versa and most often used by software vendors for developing transitional products. CMS GEMS- www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMS.html

Other tools to assist in the crosswalk are available from the AAPC - https://www.aapc.com/icd-10/codes/

Who needs training?

Training is another important area where your unique practice makeup needs to be considered. Everyone in the practice is impacted and will need training.

- Orthopaedic surgeons need training in documentation, coding, and EMR changes
- Certified coders may need to get re-certified for ICD-10 depending on their certification body
- Billers must understand ICD-10 to watch for issues and ensure claims are accurate, as well as closely monitor claims after submission and resolve denials
- Practice Managers will need to update policies, monitor implementation and ensure financial stability and physician and staff preparedness.

Questions to ask yourself to help you prepare your practice for ICD-10

1 Will you be able to submit claims?

If you use an electronic system for any or all payers, you need to know if it will be able to submit ICD-10 codes. If your system uses Version 5010 for electronic transactions, you should be able to submit ICD-10 codes. However, check with your practice management system or software vendor to make sure.

A) Sample letters that you can send to your EMR/practice management company to assess their readiness.
B) Ask payors to set-up end-to-end testing prior to October 1, 2015 to make sure your claims will be accepted.
C) Take advantage of the end-to-end testing offered by Medicare.

2 Will you be able to complete medical records?

If you use any type of electronic medical record (EMR) system in your office, you need to know if it will capture ICD-10 codes. Look at how you enter ICD-9 codes (e.g., do you type them in or select from a program). Talk to your EMR vendor about your system's capabilities for ICD-10.

3 Steps to Coding claims under ICD-10?

If you want to keep coding the same way you are now, and you only use books to code, purchase an ICD-10 code book or access the ICD-10 codes online. If your coder—or whoever is responsible for coding in your practice—cannot identify codes accurately using the code book or 'look-up' functionality in your software, explore their ICD-10 training options and determine if formal training is necessary.

A) Make sure you are using the 2014 CMS 1500 form for your billings – Table B. The form was modified in 2014 to accommodate ICD-10. ICD-10 applies to electronic and paper claims. If you submit paper claims to a clearinghouse for conversion to an electronic format, you may wish to contact them to determine if your claim submission workflow will be impacted by the switch to ICD-10.
B) Make a list of the top 20 ICD-9 codes used in your office and start to internally practice coding using ICD-10. Check your documentation and verify it supports the ICD-10 code.
C) Order ICD-10 Reference Cards prepared by NewportMed Solutions that cover over 500 commonly performed orthopaedic procedures as a starting point. The Reference Cards are available through COA: www.coa.org
Review the list of common codes for orthopaedics developed by CMS: http://www.roadto10.org/example-practice-orthopedic/
D) View educational videos entitled:
    1) "Clinical Documentation Improvement"- CMS and AHIMA- with coding examples https://engage.vevent.com/index.jsp?eid=3523&seid=89
    2) "ICD-10 and Clinical Documentation" http://www.medscape.org/viewarticle/828929
E) Make sure your documentation is complete under ICD-10. The American Health Information Management Association (AHIMA) has developed ICD-10 Documentation Tips which can be found at: http://www.coa.org/docs/ahimadocumentationtips2.pdf Use these documentation tips as a basis for your patient encounter forms and have your physicians follow these documentation tips.
F) Consider subscribing to AAOS Code-X ($649 for AAOS Fellows) the most comprehensive orthopaedic ICD-10 coding tool to help you identify the correct code to use.
G) Make sure that your EMR software drills down deep enough into the codes and does not just give you an approximate code.
H) Check to see what documentation tips are available from your EMR vendor.
I) Check to see if your EMR vendor has developed a mobile app to assist you in ICD-10 documentation/coding.

J) Even if you are ready, you cannot start using ICD-10 on Medicare claims until October 1, 2015.

4 Where do you use ICD-9 codes? Is there anywhere you use ICD-9 codes other than claims submission on your EMR?

Talk to your colleagues and keep track of your own activities for a couple of weeks. Write down or use a sticky note to mark everywhere you see an ICD-9 code as you do your job. If the code is on paper, you will need new forms (e.g., patient encounter form). If you see the code on your computer, check with your EMR or practice management system vendor to see if your system will accept ICD-10 codes.

5 Are there ways to make coding more efficient?

Think about ways to make sure the new coding does not delay payments. Look at your most common non-visit services—do any of them sometimes trigger reviews or denials related to medical necessity? It is particularly important to understand why these reviews or denials are triggered to make sure these services are correctly coded.

Resource List:

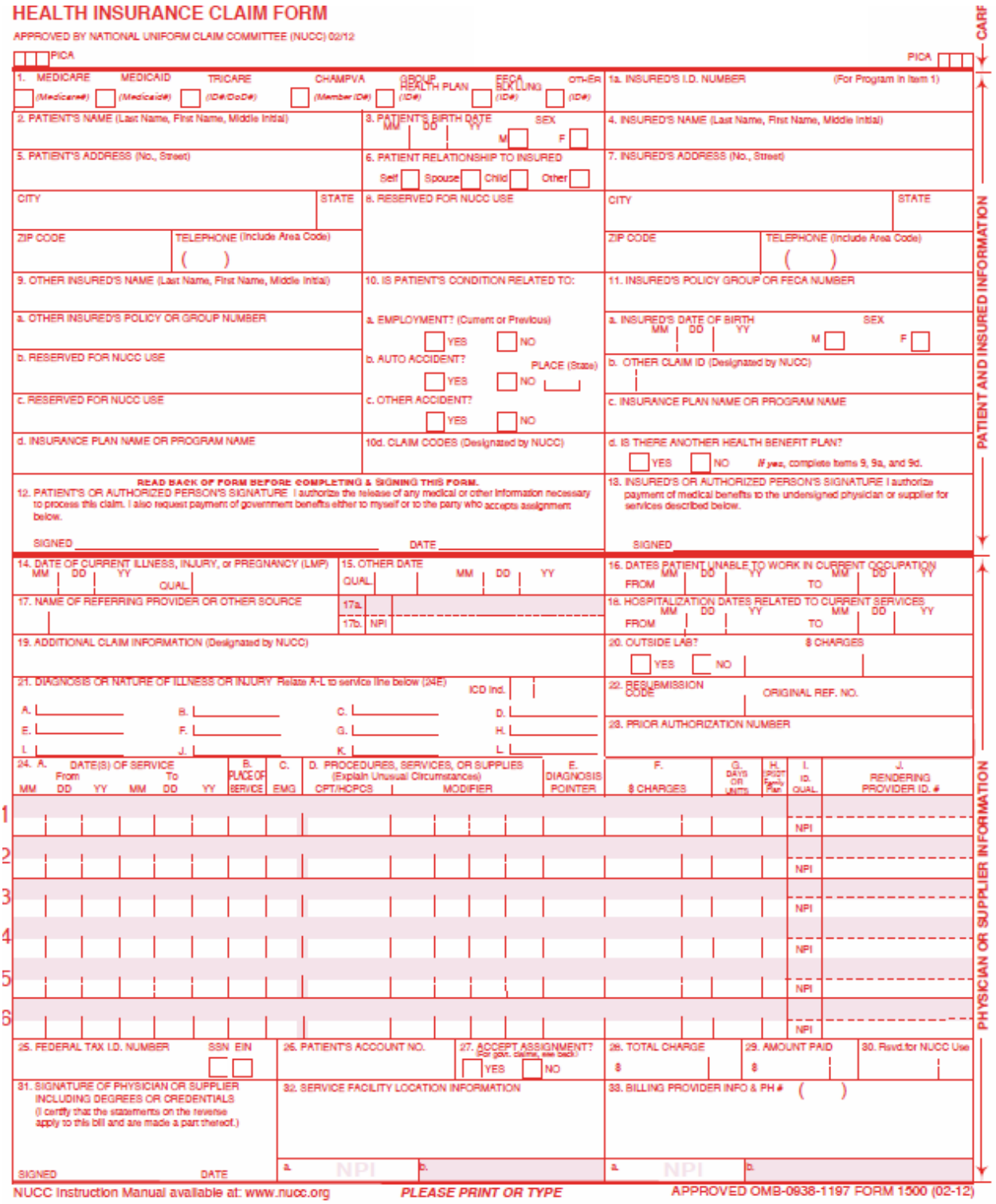
World Health Organization
List of ICD-10 codes by chapter: http://apps.who.int/classifications/icd10/browse/2015/en

American Health Information Management Association (AHIMA)
Coding Injuries in ICD-10-CM
ICD-10-CM/PCS Documentation Tips
Electronic Documentation Templates Support ICD-10-CM/PCS Implementation
ICD-10-CMS/PCS Transition: Planning and Preparation Checklist
ICD-10 Experts Push Back on Physician Concerns

Medicare CMS/AMA Frequently Asked Questions – http://www.coa.org/docs/CMSAMAFAQ.pdf
Medicare Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities
Medicare CMS- ICD-10 - http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
Medicare CMS – Road to ICD-10 - http://www.roadto10.org/
AAOS - http://www3.aaos.org/member/prac_manag/ICD-10.cfm
ICD-10: The Documentation is in the Details, AAOS Now, March, 2014
Medscape article "Preparing for ICD-10: Now is the Time by Joseph Nichols, M.D.
California Medical Association "ICD-10 Transition Guide"

Updated: 8/12/15

Table B
2014 CMS 1500 Form
Download the form: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) other (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd.for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARE

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Table C

Orthopaedic Coding Examples

Don't Let Sprain and Strain Drain Your Brain

AAOS Now article, April, 2015
By: Margaret Maley, BSN, MS, Senior Consultant with KarenZupko & Associates

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Coding Examples prepared by NewportMed Solutions

1 Colles Fracture

Clinical Concepts to Consider:

Type
- Displaced
- Nondisplaced

Localization/Laterality
- Right
- Left
- Unspecified

Episode
Initial = Active Tx Phase
- Closed
- Open type I or II
- Open type IIIA, IIIB, IIIC

Subsequent = Routine Healing phase
- Closed
- Open type I or II
- Open type IIIA, IIIIB, IIIC
- Closed with routine healing
- Open type I or II with routine healing
- Open type IIIA, IIIB, IIIC with routine healing
- Closed with delayed healing
- Open type I or II with delayed healing
- Open type IIIA, IIIB, IIIC with nonunion
- Closed with malunion
- Open type I or II with malunion
- Open type IIIA, IIIB, IIC with malunion

Sequela = Healed, but causing current condition

Subjective:
The patient is a 57-year-old right-hand-dominant female who fell 4 to 5 days ago and is continuing to have left wrist pain
Objective:
X-rays show an impacted distal radius fracture with possible intraarticular component and an associated ulnar styloid fracture
Assessment: Displaced impacted Colles fracture, left distal radius, and ulna
ICD-10 Code: - S52.532A
Colles fracture of left radius, initial encounter for closed fracture.

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2 Joint Pain – Knee

Clinical Concepts to Consider:

Localization/Laterality

- Right
- Left
- Unspecified

Subjective:

The patient is a 55-year-old male who presents for left knee joint pain. Present for 5 months. Reports burning pain. Rated as 6/10 in severity right now.

Objective:

EXAM: Wt Prior: 140 as of 11/16/06 Const: Appears healthy and well developed. Speech is appropriate. Head/Face: Normal on inspection. Facial strength normal. CV: Normal Extremities: No Cyanosis, edema or mottling. Musculo: Head/Neck: Insp/Palp: Head is erect. Symmetric. No hypertrophy. Spine: Insp/Palp: Spinal contour is normal. Increased pelvic tilt. Stability: No obvious instability. Knees: Insp/Palp: left knee normal to inspection and palpitation. Right knee normal to inspection and palpation. Stability: No instability in the left. No instability in the right. Normal muscle tone of the left knee. Normal muscle tone of the right knee. ROM: Left knee: full ROM. Right knee: full ROM. Skin: No rashes, lesions or ecchymosis.

ICD-10 Code: M25.562
Pain in the left knee

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3 Pain in Limbs

Clinical Concepts to Consider:

Caused by/ Contributing Factors

- Trauma
- Neoplasm
- Post-operative
- Psychogenic

Localization/Laterality

- Left
- Right

Anatomy

- Lower
  - Foot
- Lower Leg
  - Thigh
  - Toe
- Upper
  - Axilla
  - Finger
  - Forearm
  - Hand
  - Upper Arm

Subjective:

A 77-year-old female presents to the emergency department with mild discomfort in her right hand and left knee. Patient states that she struck her hand against something one week ago, near her right pinky knuckle (MCP). Since that time, her right index finger has become slightly red and swollen. She states that she also "banged" her left knee and has had some swelling and discomfort in the knee for the past 24 hours. She denies redness, heat of the left knee. She

denies headache, fever, neck pain, chest pain, difficulty breathing, abdominal pain, nausea, vomiting, or diarrhea. She denies numbness, tingling, or weakness.

ICD-10 Code: M79.644 – Pain in right finger(s)
M79.662 - Pain in left lower leg

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4 Femur Fracture

Clinical Concepts to Consider:

Type
- Displaced
- Nondisplaced

Localization/Laterality
- Trochaneteric
  - Apophyseal
  - Greater
  - Intertrochanteric
  - Lesser
- Right
- Left
- Unspecified

Episode

Initial Encounter
- Closed
- Open type I or II
- Open type IIIA, IIIB, IIIC

Subsequent
- Closed
- Open type I or II
- Closed with routine healing
- Open type I or II with routine healing
- Open type IIIA, IIIB, IIIC w/routine healing
- Closed with delayed healing
- Open type I or II with delayed healing
- Open type IIIA, IIIB, IIIC with delayed healing
- Closed with nonunion
- Open type IIIA, IIIB, IIIC with nonunion
- Closed with malunion
- Open type IIIA, IIIB, IIC with malunion

Sequela

Subjective: The patient is an 84-year-old man who fell onto his right hip.
Objective: An x-ray confirmed the patient sustained a closed basicervical intertrochanteric femur fracture of his right hip
Assessment: Closed basicervical/intertrochanteric femur fracture, right hip
ICD-10 Code: S72.141A
Displaced intertrochanteric fracture of right femur, initial encounter for closed fracture

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5 Tibial Fracture

Clinical Concepts to Consider:

Type
- Unspecified
- Salter-Harris I
- Salter-Harris II
- Salter-Harris III
- Salter-Harris IV

Episode
Initial
- Closed
- Open

Subsequent

- Other

Localization/Laterality

- Right
- Left
- Unspecified

- Routine healing
- Delayed Healing
- Nonunion
- Malunion

Sequela

Subjective: The patient is a 12-year-old male who has been injured while running down a hill today. He is having pain in his left ankle.
Objective: He is intact to sensation. Capillary refill of toes remains stable. No skin breakdown. AP and mortise view radiographs of left ankle were obtained and show a Salter-Harris II fracture of the distal tibia
Assessment: Left tibia fracture
ICD-10 Code: S89.122A
Salter – Harris Type II physeal fracture of lower end of tibia
Initial encounter for closed fracture

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6 Hallux Valgus

Clinical Concepts to Consider:
Localization/Laterality

- Unspecified
- Right
- Left

Subjective:
A 35 year old female patient comes in today for a bump on the side of her right foot. She also experiences aching pain and burning in her foot, especially when wearing high heels, which she wears 5 days a week.
Objective:
On examination, the patient has a bump on the side of the right foot near the big toe. The skin appears slightly red and a little swollen. X-ray was ordered and performed showing a deformity of the foot.
Assessment: Hallux Valgus
ICD-10 Code: M20.11 - Hallux valgus (acquired), right foot.

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7 Open fracture of shaft of femur:

ICD-9 Code - 821.11

Displaced comminuted fracture of shaft of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC:

ICD-10 Code - S72.351C