ICD–10 Frequently Asked Questions

Why The Change?

- ICD-9 had become obsolete
  - Had outgrown level of specificity
  - Very few unassigned codes
  - No longer accurately describe some diseases
    - Technology & Medicine have changed

- Adding 6th & 7th digits increased the number of possible codes
  - From ~14,000 (ICD-9) to ~69,000 (ICD-10)
  - Greater specificity of condition & circumstances
    - Reduces the use of unspecified codes
    - Better substantiates Medical Necessity
  - Effective Date – October 1, 2015

Grace Period

- Congress passed legislation on 07/06/15 creating a one year “grace period”
  - Beginning October 1, 2015
    - “Medicare claims will not be denied solely on the specificity of the ICD-10 diagnosis codes provided, as long as the physician submitted an ICD-10 code from an appropriate family of codes. In addition, Medicare claims will not be audited based on the specificity of the diagnosis codes as long as they are from the appropriate family of codes.”

- Quality Reporting Programs also affected
  - PQRS, VBM and MU
    - “Physicians using the appropriate family of diagnosis codes will not be penalized if CMS experiences difficulties in accurately calculating quality scores.”
  - Created an ICD-10 Ombudsman as liaison for providers experiencing difficulties
Grace Period

• If CMS experiences difficulties and unable to process claims
  • "CMS will authorize advanced payments if Medicare contractors are unable to process claims within established time limits due to problems with ICD-10 implementation."
  – This only applies to CMS (Medicare)
  • Commercial Carriers may have followed suit
  – Must still submit codes with ICD-10
  – LCDs missing some codes

ICD-10 Features

<table>
<thead>
<tr>
<th>ICD-10 Features</th>
<th>Differences</th>
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<tbody>
<tr>
<td>Combination Codes</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>(diabetes mellitus with eye conditions such as diabetic retinopathy)</td>
<td>3 - 5 Characters</td>
</tr>
<tr>
<td>Added Laterality</td>
<td>ICD-10-CM</td>
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<tr>
<td>Timeframes Added</td>
<td>3 - 7 Characters</td>
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<tr>
<td>Episodes of Care Added</td>
<td>All Characters are Numeric</td>
</tr>
<tr>
<td>External Cause Codes – no longer supplementary classification</td>
<td>No laterality</td>
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<tr>
<td>Expanded codes (diabetes, post-operative complications)</td>
<td>Character 1 is alpha (A-Z, not case sensitive)</td>
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<tr>
<td>Addition of Placeholder “X” – allows for future expansion</td>
<td>Character 2 is numeric</td>
</tr>
<tr>
<td></td>
<td>Characters 3-7 are alpha or numeric</td>
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<tr>
<td></td>
<td>Laterality</td>
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<tr>
<td>Supplemental chapters:</td>
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<td>Alpha and numeric characters</td>
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ICD-9 vs. ICD-10

<table>
<thead>
<tr>
<th>Differences</th>
<th>ICD-9-CM</th>
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<tr>
<td></td>
<td>366.22 - Total Traumatic Cataract</td>
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<tr>
<td></td>
<td>H26.131 - Total Traumatic Cataract, Right Eye</td>
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<td></td>
<td>H26.132 - Total Traumatic Cataract, Left Eye</td>
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</tr>
<tr>
<td></td>
<td>H26.133 - Total Traumatic Cataract, Bilateral Eye</td>
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Frequently Asked Questions

Or seemingly confusing questions or difficult to find answers.

Routine Eye Exams

• How should routine eye exams be coded?
  – ICD-9:
    • V72.0 – Examination of eyes & vision
  – ICD-10: Encounter for other special examination without complaint, suspected or reported diagnosis
    • Z01.00 – Encounter for examination of eyes and vision without abnormal findings
    • Z01.01 Encounter for examination of eyes and vision with abnormal findings.

Routine Eye Exams

– "with abnormal findings"
  • Is not further defined
  • Refractive errors as "abnormal findings"
  • Asymptomatic disease as "abnormal findings"
– Patient symptomatic – Z01.00 & Z01.01 cannot be used
  • Use diagnosis or symptom code
### Routine Eye Exams

- **Do any of the “Z-codes” apply?**
  - Z02.3 - Encounter for examination for recruitment to armed forces
  - Z02.4 - Encounter for examination for driving license
  - Z02.8 - Encounter for other administrative examinations
    - Admission to prison, summer camp & encounter for immigration, naturalization, premarital exam
  - Z13.5 - Encounter for screening for eye and ear disorders

### Z-Codes

- **“Z-codes” are appropriate in any healthcare setting**
  - Principal or secondary diagnosis depending on circumstances of the encounter
  - Certain “Z-codes” can only be primary
    - Contact/exposure codes may be primary for testing or secondary to identify potential risk
    - Status codes include presence of prosthetics or medical devices from past treatment

### Status Z-Codes

- **Z14 – Z99**
  - Z94.7 Corneal transplant status
  - Z96.1 Presence of intraocular lens
  - Z82.1 Family history of blindness and visual loss
  - Z83.511 Family history of glaucoma
  - Z83.518 Family history of other specified eye disorder

### Suspected Problem Not Found

- **If suspected problem not found, how do we code that?**
  - Z03.89 - Encounter for observation for other suspected diseases and conditions ruled out

- **Example:** PCP refers a pediatric patient who has epilepsy to your office for an eye exam with suspected eye condition. No disease or refractive error was found.
  - G40 – category heading for epilepsy - Likely would be rejected.

### Other Z-Codes

- **Codes Z77 – Z99 (Persons with potential health hazards related to family and personal history and certain conditions influencing health status)**
  - Z85.840 - Personal history of malignant neoplasm of eye
  - Z87.720 - Personal history of (corrected) congenital malformations of eye

- **Other Z-Codes**
  - Z90.01 - Acquired absence of eye
  - Z91.120 - Patient’s intentional underdosing of medication regimen due to financial hardship
  - Z91.128 - Patient’s intentional underdosing of medication regimen for other reason
    - Additional instruction under heading “Code first underdosing of medication (T36-T50) with fifth or sixth character 6”
Other Z-Codes

- Z79.4 Long term (current) use of insulin
  - Instruction in introduction – do not use if insulin is temporary
- Z79.51 Long term (current) use of inhaled steroids
- Z79.52 Long term (current) use of systemic steroids

Plaquenil Coding

- What about coding Plaquenil patients?
  - Z79.899 Other long term (current) drug therapy
    - Note under heading – Code also any follow-up examination (Z08-Z09)
  - Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
    - Use additional code to identify any applicable history of disease code (Z86-Z87)

Plaquenil Coding

- No instructions regarding underlying disease
- Follow ICD-9 precedent
  - For Testing
    - Z79.899 followed by the systemic disease, e.g. Rheumatoid arthritis M06.9
  - For Exam
    - M06.9 followed by Z79.899
- Do not use H35.38- Toxic maculopathy unless the patient actually has toxic maculopathy
- Code First and Code also instructions
  - Hydroxychloroquine T37.8X5

Glaucma Coding

- Can you help us with the proper way to code glaucoma?
  - Yes, ICD-10 has chapter-specific guidelines
  - Code range (H40-H42)
- Chapter 7: Diseases of Eye and Adnexa
  - Assigning glaucoma codes
    - Assign as many codes from H40, Glaucoma as needed to identify type of glaucoma, the affected eye, and glaucoma stage
    - Some codes do not have laterality or stages

Glaucma Coding

- Bilateral glaucoma stage with different types or stages
  - When patient has bilateral glaucoma and each eye is different type or stage and there is laterality
    - Assign appropriate code for each eye with 7th character for stage
  - When there is no laterality classified for a particular type of glaucoma or stage
    - Assign one code for each type of glaucoma with 7th character for stage

Glaucma Coding

- When patient has same type of glaucoma in both eyes but different stage per eye and classification does not indicate laterality
  - Assign code for type of glaucoma for each eye with 7th character for the specific glaucoma stage documented for each eye
- Patient was diagnosed with a lower stage glaucoma in a previous visit – is determined more advanced today
  - Assign code for the highest stage documented
Glaucoma Coding

- Indeterminate stage glaucoma
  - Assignment of 7th character “4” should be based on clinical documentation
  - The “4” is used for glaucoma whose stage cannot be clinically determined
    - 7th character should not be confused with the 7th character 0 (zero), unspecified
      » This character is assigned when there is no documentation regarding stage of glaucoma
  - Stage is determined by visual fields
    - Only resides in the 7th spot

Glaucoma Coding

- Coding example:
  - Bilateral low-tension glaucoma-moderate stage in both eyes - H40.1232
    - The type of glaucoma is the same in each eye
      - H40.123-
    - The stage of glaucoma is the same in each eye
      - The 2 in the 7th digit = moderate stage
      - One code is reported – H40.1232

Glaucoma Coding

-编码示例：
  - 双侧低张力性青光眼-中等阶段
    - 每只眼睛的类型相同
      - H40.123-
    - 每只眼睛的阶段相同
      - 7位数中的2表示中等阶段
      - 一个代码报告 - H40.1232

Glaucoma Coding

- 高度开放角型青光眼
  - 不包括后向性
  - 没有6位数
  - 必须在7位数上放置一个“X”作为占位符
    - H40.11X-
  - 必须有阶段
    - Resides only in the 7th spot

Glaucoma Coding

- Coding POAG Example (same patient)
  - 患者由眼科医生转诊进行青光眼评估，由于杯压不对称
  - 眼科医生基于检查、角巩膜镜检、SCODI诊断POAG OU
    - Final diagnosis is H40.11X4
      - The stage is indeterminate

Glaucoma Coding

- Coding POAG Example
  - 患者由于青光眼评估转诊
    - 患者进行视力检查
    - 眼科医生诊断POAG OU
      - 需要视力检查
        - H40.11X2
        - H40.11X4
          - 代码序列
            - H40.11X2
            - H40.11X4
              - Both are entered in to Box 21 on the CMS 1500 form
              - Point to H40.11X2 in Box 24E
Glaucoma Coding

- Patient has same type & stage of glaucoma, bilaterally
  - Planned unilateral procedure
    - Exam – Bilateral
    - Procedure – Unilateral
  - Coding Example:
    - 92014 – H40.131 – Bilateral pigmentary glaucoma – mild stage
    - 65855-RT – H40.1311 – SLT on the right eye

Glaucoma Suspect Coding

- How would we code a glaucoma suspect patient?
  - H40.00- Preglaucoma, unspecified
    - Appears to be synonymous with “suspect”
    - “Unspecified” – don’t use if another code applies
  - H40.01- Open Angle with Borderline findings, Low Risk
  - H40.02- Open Angle with Borderline findings, High Risk
    - Risk is at Provider discretion

Glaucoma Suspect Coding

- H40.03- Anatomically Narrow Angle
- H40.04- Steroid Responder
- H40.05- Ocular Hypertension
- H40.06- Primary Angle Closure without Glaucoma Damage

Complex Cataract Coding

- Can you please explain how we should be coding for complex cataract?
  - Dense cataract – H25.89 Other age-related cataract
  - H25.2 is Morgagnian or Hypermature cataract
  - Floppy iris syndrome (IFIS) – H21.81
    - Use additional code for adverse effect (T36-T50)
      - Table of Drugs and Chemicals – Tamsulosin (Flomax)
        T44.6X5 – adverse effect

Trauma/Injury Coding

- Please explain what A, D, & S means. How do they apply?
  - A – Initial Encounter
    - Actively addressing the injury
      - May be more than one encounter
  - D – Subsequent Encounter
    - Following the healing or recovery stage
  - S – Sequela
    - Following a consequence of the original injury

Trauma/Injury Coding

- Example - Patient presents with corneal abrasion of right eye
  - 1st visit
    - S05.01XA – Injury of conjunctiva and corneal abrasion without foreign body, right eye
  - 2nd & 3rd visits
    - S05.01XD following recovery
  - 4th & 5th visits – patient developed recurrent epithelial erosions OD
    - H18.831 Recurrent erosion of cornea, right eye & S05.01XS
Trauma/Injury Coding

- Corneal Laceration Example
  - Patient presents to the ER with corneal laceration OS
    - ER physician examines & places a rigid shield & refers to your cornea specialist
  - ER Physician – S05.62XA Penetrating wound without foreign body of left eye
  - Cornea specialist
    - Visit & Surgery S06.62XA
    - Follow-up exams & diagnostic tests – S06.62XD

- Post suture removal, central corneal scar
  - Corneal Scars are a known consequence of a corneal laceration
  - Cornea Specialist - H17.12 Central corneal opacity, left eye & S05.62XS

Diabetes Coding

- Can you please clarify diabetes coding?
  - Combination codes that include the presence of ophthalmic manifestations
    - No laterality
    - Severity included disease for non-proliferative disease
    - Presence or absence of macular edema
      - 6th digit 1 (with) or 9 (without)

- Bilateral non-proliferative disease
  - Same severity in each eye = one code
    - Example: E11.321 – Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
  - Different stage or findings in each eye
    - Exam assessment documentation indicates Type 2 diabetes mellitus with non-proliferative retinopathy mild OD w/o macular edema, moderate w/macular edema OS

Diabetes Coding

- How do we report the use of insulin?
  - Z79.4 - Long term (current) use of insulin
    - Long term is not further defined
  - Required for 4 of the 5 types of diabetes
    - Only Diabetes Mellitus Type 1 is excluded
  - Do not use if patient is temporarily on insulin

Blindness and Low Vision

- How do we code low vision services?
  - Descriptors are different
    - ICD-10 – Blindness & low vision
    - ICD-9 – had choices for lesser vs. better eye
      - Profound impairment
      - Moderate impairment
      - Severe impairment
      - Blindness
  - ICD-10, Chapter 7, also has table that defines categories of visual impairment
    - Laterality is required
Blindness and Low Vision

- Example - H54, Blindness, one eye, low vision other
  - Visual impairment categories 3,4,5 in one eye, with categories 1 or 2 in the other
    - H54.11 Blindness, right eye, low vision left eye
- Table for categories of impairment at the end of the code set

<table>
<thead>
<tr>
<th>Category of Visual Impairment</th>
<th>Visual Acuity with Best Possible Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minimum less than 6/18</td>
</tr>
<tr>
<td>2</td>
<td>Minimum equal to or better than 3/10 (0.3)</td>
</tr>
<tr>
<td>3</td>
<td>Minimum equal to or better than 6/60</td>
</tr>
<tr>
<td>4</td>
<td>Minimum equal to or better than 20/200</td>
</tr>
<tr>
<td>5</td>
<td>Light Perception</td>
</tr>
<tr>
<td>6</td>
<td>No Light Perception</td>
</tr>
<tr>
<td>7</td>
<td>Uncertain or unspecified</td>
</tr>
</tbody>
</table>

Eye Neoplasm Coding

- Neoplasm coding sees to be difficult for us. Any advice?
  - Code by site then by behavior
  - Malignant –
    - Skin - C44.10 - C44.19 (including canthus)
    - Eye & Adnexa - C69.0 - C69.9
      - Includes: conjunctiva, cornea, retina, choroid, ciliary body, lacrimal gland & duct, orbit & overlapping sites
    - Melanoma Eyelid – D03.1- (including canthus)
    - Carcinoma Eyelid – D04.1- (including canthus)

- Benign
  - Melanocytic nevi – D22.1- (including canthus)
  - Other Benign – D23.1- (including canthus)
    - Includes: conjunctiva, cornea, retina, choroid, ciliary body, lacrimal gland & duct, orbit & overlapping sites

- Uncertain Behavior
  - Nothing specific to eyes or adnexa
  - If “including canthus” does not apply, must use unspecified code

Meibomian Gland Dysfunction

- What about meibomian gland coding?
  - Refers Coder to “Hordeolum”
    - H00.01- through H00.02-
      - 4th digits available for coding eyelids
      - 1 = RUL, 2 = RLL, 3 = LUL, 4 = LLL
  - Hordeolum external
    - Acute pustular infection of the oil glands of Zeis – lash follicles - stye
  - Hordeolum internal
    - Acute infection or inflammation in a meibomian gland - chalazion

General Questions

- We are retina only
  - My doctors feel they need to report the patient’s glaucoma, but we don’t know what type or stage it is.
    - Do I have to call the general ophthalmologist to get the type and stage or can we use an unspecified code?
    - If we know the type, can we just use indeterminate for the stage since we won’t have access to a visual field?
General Questions

• I have heard all the patient’s diagnoses have to be reported on every visit
  – Is that true?
• I heard the primary diagnosis has to be listed first
  – We are on paper charts, we pull the diagnosis codes forward from the previous visit
    • Is it acceptable for us to simply number them?

General Questions

• Do we still use Modifiers -RT and -LT if the ICD-10 code has the laterality?
• If a patient has a corneal scar from a previous injury before he was a patient of ours do we have to find out how the injury occurred to code it?
  – Do we use the “S” as the 7th digit?

General Questions

• How do you determine if a glaucoma suspect is “High” or “Low” Risk?
• What does “Pre-glaucoma” mean?
• If a patient has both a NS cataract & a Cortical cataract in the same eye do we list both types of cataracts or use combined cataract H25.81-?

General Questions

• If recurrent corneal erosion develops after a corneal abrasion how should we code the erosion?
  – Should we use the recurrent erosion of cornea, code H18.83, or the late effect of corneal abrasion, code S05.0XS?

General Questions

• A patient had a retinal detachment repair years ago done elsewhere
  – Since we do not know the details of the detachment
    • For example if there was a single break, H33.01-, or multiple breaks, H33.02-, and since the ICD-9 “old RD” code has gone away
  – Is it acceptable to use H33.00-, unspecified retinal detachment with retinal break?