ICD-10, Part 3: Find the Right Codes

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Last month, Congress passed legislation that delayed ICD-10 implementation for at least a year. At time of press, CMS hadn't confirmed a new implementation date. If you were behind schedule with your ICD-10 preparations, this gives you an opportunity to catch up. And if you have already started training for the new codes, you won't want to lose focus. This month's Savvy Coder describes the five steps you should take to find the right ICD-10 code.

A Five-Step Process

STEP 1: Search the Alphabetic Index for a diagnostic term and get its code. The term you're looking for might not be one of the main terms in the index, but it might be listed under one of those main terms—for instance, "Congenital cataract" is listed under "Cataract." But it isn't always that easy—"Horseshoe tear of the retina (without detachment)" is listed under "Break, retina." Once you've found your term, note its ICD-10 code.

STEP 2: Find the code's listing in the Tabular List. Don't use the code you found in the Alphabetic Index without checking the Tabular List, which may include special coding instructions.

STEP 3: Read the code's instructions. The code's entry in the Tabular List may include instructions on mutually exclusive codes (known as Excludes1 notes) and glaucoma staging, to name just two examples.

STEP 4: Is it an injury or trauma? When using an injury or trauma code, add a seventh character:

- A indicates initial encounter
- D indicates subsequent encounter
- S indicates sequela

For example: A patient presents with complaints of right eye pain for two hours. A corneal abrasion is diagnosed. The code is S05.01 *Injury of conjunctiva and corneal abrasion without foreign body, right eye.* That code's entry in the Tabular List instructs you to add a seventh character. Since S05.01 is only five characters long, use X as a placeholder in the sixth position. In the seventh position, add A to indicate an initial encounter. So you would code S05.01XA. When the patient is seen in follow-up, use code S05.01XD. If the patient develops a recurrent erosion as a result of the abrasion, use code S05.01XS.

STEP 5: Is it glaucoma? For some diagnoses, the Tabular List instructs you to add a seventh character for glaucoma staging codes:

- 0 for stage unspecified
- 1 for mild
- 2 for moderate
- 3 for severe
- 4 for indeterminate

For example: The ICD-10 code for bilateral chronic angle-closure glaucoma, moderate stage is H40.2232. H40.22 represents chronic angle-closure glaucoma, the 3 indicates that it is bilateral, and the final 2 specifies that it is moderate stage. ■

Essential References

CMS publishes two complementary sets of listings.

The Alphabetic Index of diagnostic terms (plus their corresponding ICD-10 codes) should only be used as a starting point (see "Step 1").

The Tabular List of ICD-10 codes (plus their descriptors) includes any special instructions for each code (see "Step 3"). It is organized alphanumerically from A00.0 to Z99.89 and is divided into chapters based on body part or condition.

Use the *ICD-10-CM for Ophthalmology* (product #0120343) book. It provides those parts of the Alphabetic Index and Tabular List most relevant to ophthalmology, along with ICD-9/ICD-10 conversion tables for the most commonly used codes. There also is a companion book, *Conquering ICD-10-CM: Your "How-To" Guide for Ophthalmology* (#0120345), and an online course, *90 Minutes to Conquering ICD-10-CM for Ophthalmology* (#0120355V). Buy them at www.aao.org/store.