

How Well Do You Know ICD-10? Test Your Coding Competency

Remember the launch of ICD-10 in 2015? New definitions, expanded specificity and laterality, and a crosswalk from the old codes to new codes—these were at the core of the learning curve. Since then, practices’ experiences with claims denials and claims reviews have further clarified the ICD-10 rules.

Tackle the questions below to test your coding competency and improve your mastery of some core ICD-10 principles.

A Claim for an Exam Is Denied

A claim for an exam was submitted with ICD-10 codes H10.012 *acute follicular conjunctivitis, left eye* and H16.223 *keratoconjunctivitis sicca, bilateral*.

Q. Why was this claim denied?

A. ICD-10’s subchapter for conjunctivitis, H10, has an Excludes1 note for keratoconjunctivitis (H16.2-). Submitting ICD-10 codes with an Excludes1 note can prompt a payer to deny the claim. For this claim, report only the one ICD-10 code that reflects the reason for the exam.

Takeaway point. The ICD-10 rules use Excludes1 notes to flag codes that you can’t submit together. These notes are used when two conditions cannot occur together. For example, a congenital condition (e.g., Q10.2 *congenital entropion*) can’t also be an acquired condition (e.g., H02.02- *mechanical entropion*).

A Patient With Concurrent Glaucoma and Cataract

The physician orders a visual field test and an IOLMaster (Zeiss) test. When billing for those services, the practice used CPT code 92083 to report the visual field test and 92136 for the IOLMaster test. In the superbill, the practice linked the following three ICD-10 codes to both those services: H25.11 *age-related cataract, right eye*; H40.1131 *bilateral primary open-angle glaucoma, mild stage*; and E11.9 *Type 2 diabetes without complication*.

Q. Are the CPT codes linked to ICD-10 codes correctly?

A. No. The glaucoma diagnosis code alone should be linked to 92083 and the cataract diagnosis code alone to 92136. Linking all three diagnosis codes to each of those CPT codes could lead to claim denials or a focused medical review based on medical necessity.

Takeaway point. A CPT code should be linked only to the ICD-10 code that supports medical necessity for the service provided. On the CMS-1500 form, or its electronic equivalent, make sure that each CPT code reported is linked to an appropriate ICD-10 code (or codes). Each of the encounter’s ICD-10 codes should be listed in item 21 of the form. The form has space to list up to 12 ICD-10 codes, and each one is assigned a letter (“A” through “L”). These letters are used in column E (the “Diagnosis Pointer” column) of item

24 to link each of the encounter’s CPT codes to an ICD-10 code.

Sending a Lesion to the Lab

A lesion is removed from the right eyelid and sent to pathology for a confirmatory diagnosis. The assessment in the chart documents suspected malignant neoplasm.

Q. Is it appropriate to code as C44.102 unspecified malignant neoplasm of skin of right eyelid?

A. No. It is not appropriate to report an ICD-10 code for a suspected condition. You have two options: Hold the claim until a diagnosis is confirmed or code based on the current assessment. D48.1, *neoplasm of uncertain behavior*, would accurately represent the diagnosis prior to receiving the pathology report.

Takeaway point. Do not link a CPT code to a “probable,” “suspected,” “possible,” or “rule-out” ICD-10 code. Instead, link to a confirmed diagnosis.

Use These AAOE Resources

Bookmark aao.org/icd10. Brush up on the ICD-10 coding fundamentals by visiting aao.org/icd10. The latest versions of subspecialty specific guides and decision trees are available to download for free.

Buy eye care’s ICD-10 manual. The *2022 ICD-10-CM for Ophthalmology* is your complete reference for ICD-10 coding (aao.org/store).

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