

PRACTICE PERFECT

CODING & REIMBURSEMENT

ICD-10: How to Find the Correct Code in 5 Steps

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To help you prepare for the Oct. 1 implementation of ICD-10, *EyeNet* is providing an overview of the five-step process for finding ICD-10 codes (see below), along with a series of subspecialty-specific Savvy Coders, starting next month with cataract.

You'll Need These Two Lists

Before you get started, you'll need access to two sets of lists.

- **The Alphabetical Index of diagnostic terms** (plus their corresponding ICD-10 codes) lists thousands of “main terms” alphabetically. Under each of those main terms, there is often a sublist of more-detailed terms—for instance, “Cataract” has a sublist of 84 terms. However, the Alphabetical Index doesn't include coding instructions, which are in the Tabular List.
- **The Tabular List of ICD-10 codes** (plus their descriptors) is organized alphanumerically from A00.0 to Z99.89. It is divided into chapters based on body part or condition. Most ophthalmology codes are in chapter 7 (Diseases of the Eye and Adnexa),

but diabetic retinopathy codes are in chapter 4 (Endocrine, Nutritional, and Metabolic Diseases).

Order the lists today. Both can be downloaded from the CMS website (www.cms.gov/icd10). For ophthalmologists, however, the most user-friendly options are the *ICD-10 for Ophthalmology* book and the *ICD-10 for Ophthalmology Online Subscription*. Another key reference is the *Ophthalmic Coding Coach*, which will help you link CPT codes to ICD-10 codes.

A Five-Step Process

Step 1: Search the Alphabetical Index for a diagnostic term. After identifying the term, note its ICD-10 code.

Tip. 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,” and “Floppy iris syndrome” is listed under “Floppy.”

Step 2: Check the Tabular List.

Before you use the ICD-10 code that you found in the Alphabetical Index, it is important to check that code in the Tabular List to see if there are special instructions.

Example. If you looked only at the Alphabetical Index, you wouldn't know that some glaucoma diagnosis

Essential Resources

The Academy offers a rich range of resources to help you get prepared for ICD-10:

- *Ophthalmic Coding Coach* (available as a book and as an online subscription)
- *ICD-10-CM for Ophthalmology* (available as a book and as an online subscription)
- *2015 Complete Guide to Retina Coding* (book)
- *2015 Ophthalmic Coding Series Essential Topics* (book)
- *2015 Ophthalmic Coding Series: Specialty Topics* (downloadable PDFs)
- *Online Course: 90 Minutes to Conquering ICD-10-CM* (an interactive course that you can take online)
- *Conquering ICD-10-CM: Your “How To” Guide for Ophthalmology* (book)
- *Conquering ICD-10 for Ophthalmology Collection* (the *ICD-10-CM for Ophthalmology* book, *Conquering ICD-10-CM* book, and online course together)

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codes require a sixth character to represent laterality—1 for the right eye, 2 for the left eye, and 3 for both eyes—or a seventh character to represent staging (see “Step 5”).

Step 3: Read the code’s instructions. The code’s entry in the Tabular List provides all the diagnosis code requirements.

Example. The Tabular List flags any codes that can’t be submitted for the same eye on the same day (see “Meet Excludes1 and Excludes2”).

Step 4: If it is an injury or trauma, add a seventh character. Use one of the following:

- A to indicate the initial encounter
- D for a subsequent encounter
- S for sequela

Example. A patient presents with a complaint of pain in the right eye 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—A, D, or S. 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—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: If glaucoma, you may need to add a seventh character. 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

Example. The ICD-10 code H40.2232 represents bilateral chronic angle-closure glaucoma, moderate stage. Breaking that down, H40.22 represents chronic angle-closure glaucoma, the 3 in the sixth position indicates that it is bilateral, and the 2 in the seventh position represents that it is moderate stage.

Always code to the highest degree

of accuracy and completeness. If there is a fourth, fifth, sixth, or seventh digit available, you must use it.

Tip. The best code is the actual diagnosis, the next best is a sign or symptom, and the last resort is a circumstance (V code). Only code established conditions (not probable, suspected, possible, or rule out conditions).

Know the New Terminology

As you review the Alphabetical Index and Tabular List, you’ll see some new terms, the most important of which are described below.

“-” indicates that there are multiple diagnosis code options. In the Alphabetical Index, you’ll see listings in which a dash (-) appears at the end of the code: For instance, *Fragments, cataract (lens), following cataract surgery* H59.02-. The dash indicates that the Tabular List includes more specific code options, in this case for laterality—H59.021 for the right eye, H59.022 for the left, and H59.023 for both. Because you are obliged to use the most specific code available, it would be insufficient to submit H59.02 without indicating the laterality.

In the Tabular List, you will see the dash used for cross-referencing.

“And” means and/or. When “and” appears in a title—as in H26.0 *Infantile and juvenile cataract*—it means and/or.

“X” is used as a placeholder. You sometimes need to add a seventh character—for instance, to indicate glaucoma staging—to a code that only has five characters. In that case, use X as a placeholder in the sixth position.

Example. If the diagnosis is primary open-angle glaucoma, severe stage, in the right eye, submit H40.11X3. While some glaucoma codes require you to indicate laterality (using the sixth character), that’s not the case with H40.11. But you are required to indicate staging, which is done with the seventh character, so you need to use X as a placeholder.

Meet Excludes1 and Excludes2

When you look up a code in the Tabu-

lar List, you may see one or more other codes listed in an Excludes note. There are two types—Excludes1 and Excludes2—and the two serve very different purposes.

An Excludes1 note flags codes that you can’t submit together. This type of Excludes note serves the same purpose as ICD-9’s Excludes notes: It flags conditions that can’t be reported together, including mutually exclusive diagnosis codes (for instance, a congenital condition can’t also be an acquired condition).

Example. In chapter 7 of the Tabular List, H02.81 *Retained foreign body in eyelid* has an Excludes1 note that lists *Laceration of eyelid with foreign body* (S01.12-), *Retained intraocular foreign body* (H44.6-, H44.7-), and *Superficial foreign body of eyelid and periorcular area* (S00.25-). This means that if you bill one of the H02.81- codes, you can’t bill any of those other codes on the same day for the same eyelid.

In another example, H35.35 *Cystoid macular degeneration* has an Excludes1 note that lists *Cystoid macular edema following cataract surgery* (H59.03-).

An Excludes2 note flags codes that you may be able to bill for the same eye on the same day. When a code’s listing includes an Excludes2 note, the code(s) listed in that note are ones that a) are not part of the condition that is represented by the main code and b) can—when appropriate—be reported together with the main code.

Example. H11.1 *Conjunctival degenerations and deposits* has an Excludes2 note that lists H11.81 *Pseudopterygium*. This means that ICD-10 doesn’t include pseudopterygium as part of any condition represented by the H11.1- codes, but it is possible for a patient to have both at the same time—and if that’s the case with your patient, you would submit the relevant H11.1- code along with H11.81.

Getting Ready for ICD-10

For a to-do list, visit www.aao.org/icd10 and select “Checklist for Transition.” For instance, you should create a list of your most frequently used diagnoses and find their ICD-10 codes. ■