How to Use the ICD-10 Codes for Age-Related Macular Degeneration

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The ICD-10 codes for age-related macular degeneration (AMD) involve both laterality and staging. Correct staging enables more accurate characterization, which is important for understanding risk for visual loss; it also helps to ensure accurate documentation and efficient billing.

Coding for Laterality in AMD

When you use the codes for dry AMD (H35.31xx) and wet AMD (H35.32xx), you must use the sixth character to indicate laterality as follows:

1 for the right eye
2 for the left eye
3 for bilateral

Tip. If the same disease stage is present in both eyes, use the bilateral designation (3) regardless of whether 1 or both eyes are being treated.

The treatment code should indicate which eye is being treated.

Coding for Staging in Dry AMD

The codes for dry AMD—H35.31xx—use the seventh character to indicate staging as follows:

H35.31x1 for early dry AMD—a combination of multiple small drusen (≤ 63 µm), few intermediate drusen (> 63 µm and ≤ 124 µm), or retinal pigment epithelium (RPE) abnormalities.

H35.31x2 for intermediate dry AMD—extensive intermediate drusen (> 63 µm and ≤ 124 µm) or at least 1 large drusen (≥ 125 µm).

H35.31x3 for advanced atrophic dry AMD without subfoveal involvement—geographic atrophy (GA) not involving the center of the fovea.

H35.31x4 for advanced atrophic dry AMD with subfoveal involvement—GA involving the center of the fovea.

Defining Geographic Atrophy

When is the retina considered atrophic?

The Academy *Preferred Practice Pattern*[1] defines GA as follows:

> The phenotype of central geographic atrophy, the advanced form of non-neovascular AMD, will have 1 or more zones of well-demarcated RPE and/or choriocapillaris atrophy. Drusen and other pigmentary abnormalities may surround the atrophic areas. Severe visual acuity loss occurs less commonly and more slowly in patients with geographic atrophy than in patients with neovascular AMD. Nevertheless, geographic atrophy involving the foveal center causes approximately 10% of all AMD-related visual loss of 20/200 or worse.[2] Patients with geographic atrophy not necessarily involving the central fovea may have relatively good distance visual acuity yet manifest a substantially decreased ability to perform near visual tasks such as reading.[2] Doubling of the visual angle in patients with geographic atrophy has been reported to occur in as many as 50% of patients over a 2-year period.[2] Choroidal neovascularization also may occur.

Table 1: Dry Age-Related Macular Degeneration (AMD)

	Right Eye	Left Eye	Bilateral
Dry (nonexudative) AMD, early dry stage	H35.3111	H35.3121	H35.3131
Dry (nonexudative) AMD, intermediate dry stage	H35.3112	H35.3122	H35.3132
Dry (nonexudative) AMD, advanced atrophic without subfoveal involvement	H35.3113	H35.3123	H35.3133
Dry (nonexudative) AMD, advanced atrophic with subfoveal involvement	H35.3114	H35.3124	H35.3134

Key: Red numerals (6th position) indicate laterality; green numerals (7th position) indicate staging.

Table 2: Wet Age-Related Macular Degeneration (AMD)

	Right Eye	Left Eye	Bilateral
Wet (exudative) AMD, with active choroidal neovascularization	H35.3211	H35.3221	H35.3231
Wet (exudative) AMD, with inactive choroidal neovascularization	H35.3212	H35.3222	H35.3232
Wet (exudative) AMD, inactive scar	H35.3213	H35.3223	H35.3233

Key: Red numerals (6th position) indicate laterality; green numerals (7th position) indicate staging.

Coding for Geographic Atrophy

The Academy recommends that when coding, you indicate whether the GA involves the center of the fovea: Code H35.31x4 if it does and H35.31x3 if it doesn't, with "x" indicating laterality (see previous page). Improved categorization of GA will help in clinical practice and also will lead to a better understanding of the natural history, comorbidities, and visual prognosis associated with the disease.

Why use a diagnosis code in the absence of an approved therapy? Accurate documentation and coding will help researchers and policymakers track the visual impairment and visual function deficits that are associated with the condition. Furthermore, when treatments do become available, you will be ready to code for them.

Prognosis. The risk of vision loss is higher with the involvement of the macula; however, there can be difficulties with visual function in patients with GA without subfoveal involvement. The Academy *Basic and Clinical Science Course*[3] notes the following regarding prognosis of patients with GA:

> GA often spares the fovea until late in the course of the disease. It may first present as 1 or more noncontiguous patches of atrophy around the fovea. These patches enlarge and coalesce and may be associated with a dense paracentral scotoma, thereby limiting tasks such as reading. Patients with GA may demonstrate good visual acuity (VA) until late in the course of the disease, when the fovea becomes progressively atrophic, leading to severe visual acuity decline from central blindness and forcing the patient to use noncentral retina and eccentric fixation to read and perform other visual tasks.
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> Although not all eyes with drusen or PED [pigment epithelial detachment] will develop atrophy, the incidence of atrophy appears to increase with age. Twelve to 20% of patients with GA have severe vision loss, and 10% of patients with AMD and a visual acuity of 20/200 or less have GA.

Coding for Staging in Wet AMD

The codes for wet AMD—H35.32xx—use the sixth character to indicate laterality and the seventh character to indicate staging as follows:

H35.32x1 for active choroidal neovascularization (CNV), which involves either (1) an AMD-related CNV lesion that shows disease activity (i.e., presence of intraretinal fluid [IRF] or subretinal fluid [SRF]) contributing to the patient's visual impairment or (2) an AMD-related CNV lesion that does not show disease activity (no IRF or SRF) in the presence of regular anti–vascular endothelial growth factor (VEGF) injections but shows recurrence of the disease activity (i.e., IRF/SRF) when anti-VEGF therapy is not given at appropriate intervals.

H35.32x2 for inactive CNV, which involves an AMD-related CNV lesion that no longer shows disease activity (i.e., no IRF/SRF) that contributes to the patient's visual impairment.

H35.32x3 for inactive scar, which involves an AMD-related CNV lesion that has become a disciform scar, causing visual impairment. The CNV lesion may or may not show disease activity (i.e., IRF/SRF), but it is deemed visually insignificant given the underlying disciform scar.

Defining inactive CNV (H35.2x2) and inactive scar (H35.2x3) in wet AMD. For the purpose of these ICD-10 codes, the Academy defines inactive CNV as the absence of IRF or SRF. However, the same eye can have active CNV after the diagnosis of inactive CNV, and treatment can be considered at the time of active CNV. Similarly, an eye that has an inactive scar could have active CNV after the diagnosis of an inactive scar, and treatment can be considered at the time of active CNV.

1 American Academy of Ophthalmology Retina/Vitreous Panel. *Preferred Practice Pattern Guidelines: Age-Related Macular Degeneration.* San Francisco, Calif.: American Academy of Ophthalmology; 2015. Available at: aao.org/ppp.

2 Sunness JS et al. *Ophthalmology.* 1997;104(10):1677-1691.

3 American Academy of Ophthalmology *BCSC* Subcommittee. *BCSC. Section 12: Retina and Vitreous,* 2016-2017. San Francisco, Calif: American Academy of Ophthalmology; 62-63.