Introduction to ICD-10 Coding for Eyecare
May 3, 2014

Jeffrey Restuccio, CPC, CPC-H, MBA
Coding and Billing Consultant specializing in Eyecare
Memphis TN
(901) 517-1705
jeff@eyecodingforum.com
www.EyeCodingForum.com

Sponsored by

Eyefinity
You Have More Time to Prepare

• Let’s use it wisely
• All providers must review ICD-10 basics for at least 2 hours in 2014. Six hours is recommended.
• Over 90% of the detail and complexity of ICD-10 is in ICD-9 and can implemented today.
• Preparing for ICD-10 is not a clerical function; it is primarily a documentation function—and then a coder/biller translates the documentation to the specific ICD-10 codes.
• Establishing communication between administrative staff and the providers is essential to implementing ICD-10.
Top Misconceptions

• That ICD-10 does not improve clinical care. It will.
• That ICD-10 is time-consuming. While there will be a learning curve, most can be learned in 6-12 weeks. It’s all about creating good habits.
• That a practice management, EMR, or computer program can code ICD-10 for you. EHRs can help significantly, but only if the quality of the provider’s documentation is high. You’re responsible for the patient’s record, not the EHR”
• ICD-10 only costs you money. But it can make you money as well. Reviewing your fee ticket and analyzing the suite of diseases and conditions you currently treat, can be used to increase and market your medical services.
Learn ICD-9 Guidelines Now!

- Before you can learn ICD-10 guidelines you need to learn ICD-9 guidelines. Many Eyecare professionals have never had formal ICD-9 coding training.
- The top ICD-9 concepts most Eyecare professionals do not know:
  1. 5th-digit specificity for certain codes.
  2. Reporting two codes when required, instead of just one (i.e., diabetic cataracts, secondary glaucoma, infectious diseases).
  3. Combination codes (reporting one code for two conditions).
  4. Coding for late effects (e.g., rust rings).
  5. Reporting E codes, one for the injury, and one for the location of the injury.
  6. Reporting E codes for adverse effects.
  7. Screening V codes. (i.e., V72.0)
Specifics

- ICD-10-CM is an updated system for the reporting of diseases, conditions and other factors affecting healthcare (i.e., injuries and adverse effects).
- Each ICD-10-CM code consists of 3 to 7 characters, the first being a letter of the alphabet (alpha character), the second a number, and the rest either alpha or numeric.
- New ICD-10 codes must be used effective Oct 1 2015.
- ICD-10 has 68,000 codes compared to only 13,000 ICD-9 codes.
- The “CM” means “clinical modifications” and is unique to the descriptions of the codes used in the United States.
ICD-10 Code Format

- [ ] [ ] [ ] [ ]. [ ] [ ] [ ] [ ] Category (letter), etiology, anatomic site, severity and then a **seventh-digit** "extender"

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B20</td>
<td>Human immunodeficiency virus [HIV] disease</td>
</tr>
<tr>
<td>D31.32</td>
<td>Benign neoplasm of left choroid</td>
</tr>
<tr>
<td>E11.9</td>
<td>Type 2 diabetes mellitus without complications</td>
</tr>
<tr>
<td>H00.11</td>
<td>Chalazion right upper eyelid</td>
</tr>
<tr>
<td>H40.11X1</td>
<td>Primary open-angle glaucoma, mild stage</td>
</tr>
<tr>
<td>H52.11</td>
<td>Myopia, right eye</td>
</tr>
<tr>
<td>H52.4</td>
<td>Presbyopia</td>
</tr>
<tr>
<td>R51</td>
<td>Headache</td>
</tr>
<tr>
<td>T15.02XA</td>
<td>Foreign body in cornea, left eye, initial encounter</td>
</tr>
<tr>
<td>Z96.1</td>
<td>Presence of intraocular lens</td>
</tr>
</tbody>
</table>
Why Are There So Many Codes?

• Much of the increase is due to the addition of “laterality” and bilateral anatomy and disease codes (right, left, bilateral, and unspecified).
• In other words, each eye condition or disease will have **four codes** instead of one. However I do not recommend including “**unspecified eye**” on your fee ticket or **ever** reporting it.
• There is also some increased specificity.
• Some ICD-9 codes will become two ICD-10 codes.
• There are new disease phrasing and coding guidelines in ICD-10.
• Diabetes, glaucoma, and injury codes represent the largest increase in codes, relevant to Eyecare.
Won’t my Billing System do all of this for me?

• Is simply upgrading your practice management system or electronic health records systems sufficient to properly document and report ICD-10 codes? Won’t it have everything I need?

• The simple answer is “No.” The reasons include: lack of crosswalk of some codes, lack of complete definitions, lack of acronyms and common terminology, lack of enhanced descriptions and explanations, and lack of coding guideline (code also) information.

• Plus, the provider must document the **specific medical diagnoses** clearly in the medical record. The documentation comes first—then the specific diagnosis codes are translated into codes and entered into the practice management system.

• The goal is to create good documentation and coding habits.
ICD-10 Training

1. The majority of Eyecare ICD-9 codes crosswalk cleanly to ICD-10. However, it’s the other 10-15% of diseases that will cause the most problems.

2. It is best to learn the **guidelines and numerous sub-terms** early and practice them at least three months before the implementation date of Oct 1 2015.

3. Conduct a thorough **audit** of provider documentation today.

4. Review any documentation concerning ICD-10 from carriers. Medicare is always your first source; next would be Blue Cross/Blue Shield. Also check your local Medicaid and all vision plans.

5. **Review** your practice management and your EMR system.

6. Establish an **ICD-10 review team**.
Documentation Issues

• Each clinic should establish documentation policies.
• Staff should review ICD-10 guidelines.
• Decide how codes are selected. Are you going to code from the manual, a cheat sheet or a look-up program to select the new ICD-10 codes?
• All fee tickets must be reworked. Recommendation is between three to six months before Oct 1 2015.
• Practice the specific, detailed codes starting at least three months (July 1) before implementation on Oct 1 2015.
Audit Progress Notes for Specificity

• Accurate, specific, well-documented encounters, that clearly reflect a knowledge of coding guidelines and documentation requirements are much more likely to “sail through” an audit.

Avoid documenting *unspecified*:

• Diabetes Mellitus
• Keratoconus
• Headaches
• ARMD
• Entropion
• Ectropion
• Lagophthalmos

• Astigmatism
• Cataracts
• Keratitis
• Conjunctivitis
• Epiphora
Action Plan to Prepare for ICD-10

• **Circle** all unspecific ICD-9 codes in your current fee ticket/ICD-9 cheat sheet and provider documentation.

• You should **generate a list** of every ICD-9 code you have reported for the last 12 months from your PM system. You can use this list to create your new ICD-10 fee ticket or cheat sheet.

• Discuss with your provider if it is **reasonable** to provide additional documentation and more specificity.

• Discuss if a “**jury of their peers**” would agree if called before an optometry board, Medicaid, VSP, or Medicare panel concerning your documentation.
ICD-10 Highlights

• **Laterality:**
  - Document and report eye conditions by eye when applicable.
  - The right, left and bilateral eye conventions are:
    - **1 = right eye**
    - **2 = left eye**
    - **3 = bilateral (both eyes)**
    - **9 = unspecified eye [recommend not using]**

But there are exceptions!
Eyelid Codes

- ICD-10 Eyelid Codes follow the HCPCS E codes (1 - 4) There are now **seven options** for each eyelid!
- **1 = RUL (Right Upper Lid)**
- **2 = RLL (Right Lower Lid)**
- **3 = Right Eye (unspecified lid) - Don’t Use**
- **4 = LUL (Left Upper Lid)**
- **5 = LLL (Left Lower Lid)**
- **6 = “Left Eye (unspecified lid) - Don't Use**
- **9 = “Unspecified eye; unspecified lid - Don't Use**
Lacrimal Gland Codes

- **Lacrimal Gland Codes (1,2,3, 9)** map to RT, LT, bilateral and unspecified. An example is below:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H04.011</td>
<td>Acute dacryoadenitis, right lacrimal gland</td>
</tr>
<tr>
<td>H04.012</td>
<td>Acute dacryoadenitis, left lacrimal gland</td>
</tr>
<tr>
<td>H04.013</td>
<td>Acute dacryoadenitis, bilateral lacrimal glands</td>
</tr>
<tr>
<td>H04.019</td>
<td>Acute dacryoadenitis, unspecified lacrimal gland</td>
</tr>
</tbody>
</table>
The ICD-10 “X” Placeholder Code

• Occasionally one will find an “X” character in the middle of an ICD-10 code.
• Example: T15.01XA Foreign body in cornea, right eye, initial encounter.
• In this case, the “X” in the sixth-digit position serves as a placeholder so that the seventh character is in the correct position. Without the placeholder, the resulting code would be invalid.
• Placeholder codes are also in some ICD-10 glaucoma codes.
Occurrence codes

• All injury codes will now have the following occurrence codes and an “X” placeholder code.

• Foreign Body (FB) codes (Note: XA, XD and XS) Initial, Subsequent and Sequela:
  • T15.01XA  Foreign body in cornea, right eye, initial encounter
  • T15.01XD  Foreign body in cornea, right eye, subsequent encounter
  • T15.01XS  Foreign body in cornea, right eye, sequela
Late Effects and Occurrence codes

- The term "Late Effect" is not found in ICD-10. They are now listed as Sequela, which are reported using the external cause code with the 7th character “S” for sequela.
- Like late effects, a sequela can occur at any time after the initial injury.
- The most common ICD-10 sequelas would be from burns, foreign bodies, or penetrating injuries to the eyes and adnexa.
- T15.01XS Foreign body in cornea, right eye, sequela
## Conditions without Laterality

- These are **Not** reported by eye.
- H53.2 diplopia is a 4 digit code. By its very nature, it only applies to both eyes therefore only **one selection**, not four.
- Diabetes codes – In ICD-10 just one code. No laterality (not by eye).
- ARMD codes – No laterality (not by eye).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H53.10</td>
<td>Unspecified subjective visual disturbances</td>
</tr>
<tr>
<td>H53.16</td>
<td>Psychophysical visual disturbances</td>
</tr>
<tr>
<td>H53.19</td>
<td>Other subjective visual disturbances</td>
</tr>
<tr>
<td>H53.8</td>
<td>Other visual disturbances</td>
</tr>
<tr>
<td>H53.9</td>
<td>Unspecified visual disturbance</td>
</tr>
</tbody>
</table>
Diabetes Is Not Coded By Eye

• E10.*** Type 1 DM
• E11.*** Type 2 DM
• ICD-10-CM classifies inadequately controlled, out of control, and poorly controlled diabetes mellitus by type with hyperglycemia.
• In ICD-10 ophthalmic diabetic manifestations are now one combination code instead of two codes in ICD-9.
Routine Eye Exam

• The “routine exam of eyes” code (V72.0) changes to two codes with ICD-10: without [Z01.00] and with [Z01.01] abnormal findings
• Z01.00 Encounter for examination of eyes and vision without abnormal findings.
• Z01.01 Encounter for examination of eyes and vision with abnormal findings.
• The word “routine” is no longer in the description.
• It will be very important to monitor how vision plans and insurance companies reimburse based on the two ICD-10 codes above linked to office visits.
More Highlights

• Bacterial and viral diseases will become A and B codes.
• Malignant neoplasms will become C codes.
• Benign neoplasms (nevus) will become D codes.
• There is no "senile cataract" description in ICD-10; they are now listed as "age-related."
• E codes (Accidents, poisonings, injuries, and adverse effects) become S and T codes in ICD-10.
• W and Y codes are used to indicate activities and locations for injuries and accidents.
• All ICD-9 “V” encounter and status codes become ICD-10 Z codes.
H52.***: Refraction Disorders

- These codes are **not medical diagnoses**.
- They should primarily be used with **CPT code 92015**.
- While some medical insurance carriers and most vision plans accept them as linked diagnoses, the ICD-10 Z01.** routine vision exam codes below should be linked to 920** and 992** office visits when there is no medical diagnosis.
- **Medicare** never pays on 92015 and refraction diagnosis codes. However some medical insurance carriers pay on **medical diagnosis codes** linked to **92015**.
Hyperopia

- Hypermetropia=hyperopia=farsightedness. Patient can see in the distance. Eyeball is too short.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H52.00</td>
<td>Hypermetropia, unspecified eye [exception is zero, not a 9]</td>
</tr>
<tr>
<td>H52.01</td>
<td>Hypermetropia, right eye</td>
</tr>
<tr>
<td>H52.02</td>
<td>Hypermetropia, left eye</td>
</tr>
<tr>
<td>H52.03</td>
<td>Hypermetropia, bilateral</td>
</tr>
</tbody>
</table>

**Emmetropia**: normal refractive status.
Myopia

- Myopia=nearsightedness. Patient can see close-up. Eyeball is too long.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H52.10</td>
<td>Myopia, unspecified eye [exception]</td>
</tr>
<tr>
<td>H52.11</td>
<td>Myopia, right eye</td>
</tr>
<tr>
<td>H52.12</td>
<td>Myopia, left eye</td>
</tr>
<tr>
<td>H52.13</td>
<td>Myopia, bilateral</td>
</tr>
</tbody>
</table>
Presbyopia

- Inability to see close-up (reading, over 40)

| H52.4 | Presbyopia [No Laterality] |
**H52.2**: Astigmatism

- **Regular astigmatism**: principal meridians are perpendicular.
- **Irregular astigmatism**: principal meridians are not perpendicular.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H52.201</td>
<td>Unspecified astigmatism, right eye [KOD*] [Laterality]</td>
</tr>
<tr>
<td>H52.211</td>
<td>Irregular astigmatism, right eye [Laterality]</td>
</tr>
<tr>
<td>H52.221</td>
<td>Regular astigmatism, right eye [Laterality]</td>
</tr>
</tbody>
</table>

Note all codes above are right eye only to conserve space. Each selection above has 4 ICD-10 codes.

*Kiss of Death* means you may be denied if you use too many unspecified codes (carrier specific)
Ophthalmoplegia

- **Ophthalmoplegia** (Ophthalmoparesis) refers to weakness or paralysis of one or more extraocular muscles which are responsible for eye movements. It is a physical finding in certain neurologic illnesses.

- **Two types**, external and internal. **External** is a medical diagnosis code. **Internal** is a refraction diagnosis code.

- See next slide for external codes.

- Note: These are **not H52.*** **codes.**
Ophthalmoplegia (External)

Note how a zero (fifth digit) indicates an unspecified eye (exception). All laterality options are listed below.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H49.30</td>
<td>Total (external) ophthalmoplegia, unspecified eye</td>
</tr>
<tr>
<td>H49.31</td>
<td>Total (external) ophthalmoplegia, right eye</td>
</tr>
<tr>
<td>H49.32</td>
<td>Total (external) ophthalmoplegia, left eye</td>
</tr>
<tr>
<td>H49.33</td>
<td>Total (external) ophthalmoplegia, bilateral</td>
</tr>
<tr>
<td>H49.40</td>
<td>Progressive external ophthalmoplegia, unspecified</td>
</tr>
<tr>
<td>H49.41</td>
<td>Progressive external ophthalmoplegia, right eye</td>
</tr>
<tr>
<td>H49.42</td>
<td>Progressive external ophthalmoplegia, left eye</td>
</tr>
<tr>
<td>H49.43</td>
<td>Progressive external ophthalmoplegia, bilateral</td>
</tr>
</tbody>
</table>
H52.5**: Ophthalmoplegia and Accommodation Disorders

- **Internal ophthalmoplegia** is characterized by paresis of ciliary body with loss of power of accommodation and pupil dilation because of lesions of ciliary ganglion. This is a refraction code.
- **Paresis**: a weakness of voluntary movement.
- All these codes have *laterality* (1,2,3,9) **options**.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H52.511</td>
<td>Internal ophthalmoplegia (complete) (total), right eye</td>
</tr>
<tr>
<td>H52.521</td>
<td><strong>Paresis</strong> of accommodation, right eye</td>
</tr>
<tr>
<td>H52.531</td>
<td><strong>Spasm</strong> of accommodation, right eye</td>
</tr>
</tbody>
</table>
Common Signs and Symptoms

- **H43.39**: Floaters, **right eye** [Laterality]
- **H53.16**: Halos
- **H53.8**: Blurred Vision (Other visual disturbances)
- **H57.9**: Red Eyes
- **H57.1**: Eye pain, **right eye** [Laterality]
- **I10**: Hypertension essential, benign, malignant.

- **Floaters**: Disorders of vitreous body: other vitreous opacities
- **Halo**: is a hazy ring around bright lights seen by some patients with refractive error or optical defects, (e.g., cataracts, or corneal swelling).
Common Signs and Symptoms

• Avoid the unspecified code if possible.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R11.0</td>
<td>Nausea</td>
</tr>
<tr>
<td>R11.10</td>
<td>Vomiting, unspecified</td>
</tr>
<tr>
<td>R11.11</td>
<td>Vomiting without nausea</td>
</tr>
<tr>
<td>R11.2</td>
<td>Nausea with vomiting, unspecified</td>
</tr>
</tbody>
</table>

H21.561 | Non-Reactive Pupil [pupillary abnormality] [right eye]

• **Never report** nausea and vomiting separately when there is a combination code [R11.2] for both.
Family and Personal History Codes

- Report a family history code for those patients with a refraction Dx and a family history of eye disease; it’s proper coding.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z82.1</td>
<td>Family history of blindness and visual loss</td>
</tr>
<tr>
<td>Z83.511</td>
<td>Family history of glaucoma</td>
</tr>
<tr>
<td>Z83.518</td>
<td>Family history of other specified eye disorder</td>
</tr>
<tr>
<td>Z94.7</td>
<td>Corneal transplant status</td>
</tr>
<tr>
<td>Z85.840</td>
<td>Personal history of malignant neoplasm of eye</td>
</tr>
<tr>
<td>Z87.720</td>
<td>Personal history of (corrected) congenital malformations of eye</td>
</tr>
</tbody>
</table>
More Family History and Status Codes

- I do not know of any medical carriers that pay an office visit linked to only a history code. **Visions Plans** are entirely different and most reimburse for a “routine vision” exam regardless of the diagnosis code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z82.49</td>
<td>Family history of ischemic heart disease and other diseases of the circulatory system</td>
</tr>
<tr>
<td>Z83.3</td>
<td>Family history of diabetes mellitus</td>
</tr>
<tr>
<td>Z83.49</td>
<td>Family history of other endocrine, nutritional and metabolic diseases</td>
</tr>
<tr>
<td>Z91.19</td>
<td>Patient's <strong>noncompliance</strong> with other medical treatment and regimen</td>
</tr>
</tbody>
</table>
ICD-9 Glaucoma Stage Codes

- In ICD-9, report both the glaucoma type and a separate stage code when appropriate.

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Stages</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>365.70</td>
<td>glaucoma stage, unspec</td>
<td>0</td>
</tr>
<tr>
<td>365.71</td>
<td>glaucoma stage, mild</td>
<td>1</td>
</tr>
<tr>
<td>365.72</td>
<td>glaucoma stage, moderate</td>
<td>2</td>
</tr>
<tr>
<td>365.73</td>
<td>glaucoma stage, severe</td>
<td>3</td>
</tr>
<tr>
<td>365.74</td>
<td>glaucoma stage, indeterminate stage</td>
<td>4</td>
</tr>
</tbody>
</table>
Primary Open Angle Glaucoma

- This code does not have laterality. There is a 6th digit placeholder code.
- Stage codes will not be reported separately and in addition to the primary glaucoma codes. ICD-10 Glaucoma stage codes will now be a seventh digit character.
- The seventh-digit stage options are 0, 1, 2, 3 and 4.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H40.11X0</td>
<td>Primary open-angle glaucoma, stage unspecified</td>
</tr>
<tr>
<td>H40.11X1</td>
<td>Primary open-angle glaucoma, mild stage</td>
</tr>
<tr>
<td>H40.11X2</td>
<td>Primary open-angle glaucoma, moderate stage</td>
</tr>
<tr>
<td>H40.11X3</td>
<td>Primary open-angle glaucoma, severe stage</td>
</tr>
<tr>
<td>H40.11X4</td>
<td>Primary open-angle glaucoma, indeterminate stage</td>
</tr>
</tbody>
</table>
Pseudoexfoliation syndrome is a systemic disorder in which a flaky, dandruff-like material peels off the outer layer of the lens within the eye. Worldwide, it is a common cause of secondary glaucoma.

H40.1413 Capsular glaucoma with pseudoexfoliation of lens, right eye, severe stage

ICD-9: 365.52 Pseudoexfoliation glaucoma and
ICD-9: 365.73 Severe stage glaucoma [two codes]

ICD-10 Eye Code:
Sixth digit: (1,2,3,9) Laterality (Right, Left, Bilateral and unspecified).
Seventh digit: (0,1,2,3,4) Glaucoma stage code
# Pseudoexfoliation glaucoma (20 codes)

<table>
<thead>
<tr>
<th></th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>H40.1410</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, <strong>right eye</strong>, stage unspecified</td>
</tr>
<tr>
<td>2</td>
<td>H40.1411</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, right eye, mild stage</td>
</tr>
<tr>
<td>3</td>
<td>H40.1412</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, right eye, moderate stage</td>
</tr>
<tr>
<td>4</td>
<td>H40.1413</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, right eye, severe stage</td>
</tr>
<tr>
<td>5</td>
<td>H40.1414</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, right eye, indeterminate stage</td>
</tr>
<tr>
<td>6</td>
<td>H40.1420</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, <strong>left eye</strong>, stage unspecified</td>
</tr>
<tr>
<td>7</td>
<td>H40.1421</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, left eye, mild stage</td>
</tr>
<tr>
<td>8</td>
<td>H40.1422</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, left eye, moderate stage</td>
</tr>
<tr>
<td>9</td>
<td>H40.1423</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, left eye, severe stage</td>
</tr>
<tr>
<td>10</td>
<td>H40.1424</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, left eye, indeterminate stage</td>
</tr>
<tr>
<td>11</td>
<td>H40.1430</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, <strong>bilateral</strong>, stage unspecified</td>
</tr>
<tr>
<td>12</td>
<td>H40.1431</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, bilateral, mild stage</td>
</tr>
<tr>
<td>13</td>
<td>H40.1432</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, bilateral, moderate stage</td>
</tr>
<tr>
<td>14</td>
<td>H40.1433</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, bilateral, severe stage</td>
</tr>
<tr>
<td>15</td>
<td>H40.1434</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, bilateral, indeterminate stage</td>
</tr>
<tr>
<td>16</td>
<td>H40.1490</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, <strong>unspecified eye</strong>, stage unspecified</td>
</tr>
<tr>
<td>17</td>
<td>H40.1491</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, mild stage</td>
</tr>
<tr>
<td>18</td>
<td>H40.1492</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, moderate stage</td>
</tr>
<tr>
<td>19</td>
<td>H40.1493</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, severe stage</td>
</tr>
<tr>
<td>20</td>
<td>H40.1494</td>
<td>Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, indeterminate stage</td>
</tr>
</tbody>
</table>
# Macula and ARMD

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
<th>ICD-10 code and description</th>
</tr>
</thead>
<tbody>
<tr>
<td>362.51</td>
<td>ARMD dry</td>
<td>H35.31 ARMD dry [No Laterality]</td>
</tr>
<tr>
<td>362.52</td>
<td>ARMD wet</td>
<td>H35.32 ARMD wet [No Laterality]</td>
</tr>
<tr>
<td>362.57</td>
<td>Drusen</td>
<td>H35.361 Drusen (degenerative) of macula, right eye.</td>
</tr>
<tr>
<td>377.21</td>
<td>Drusen, optic disc</td>
<td>H47.321 Drusen of the optic disc, right eye. [Laterality]</td>
</tr>
</tbody>
</table>
## Diabetes

- **ICD-9 Fourth digit = 0, no manifestation**

<table>
<thead>
<tr>
<th>250.00</th>
<th>DM II, controlled</th>
<th>=&gt;</th>
<th>E11.9 Type 2 diabetes mellitus without complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.01</td>
<td>DM I, controlled</td>
<td>=&gt;</td>
<td>E10.9 Type 1 diabetes mellitus without complications</td>
</tr>
<tr>
<td>250.02</td>
<td>DM II, uncontrolled</td>
<td>=&gt;</td>
<td>E11.65 Type 2 diabetes mellitus with hyperglycemia</td>
</tr>
<tr>
<td>250.03</td>
<td>DM I, uncontrolled</td>
<td>=&gt;</td>
<td>E10.65 Type 1 diabetes mellitus with hyperglycemia</td>
</tr>
</tbody>
</table>

8 codes (typically not reported by many clinics) plus manifestation code
Diabetes

- ICD-9 Fourth digit = 5, with **Ophthalmic manifestation**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.50</td>
<td>DM II, controlled</td>
</tr>
<tr>
<td>250.51</td>
<td>DM I, controlled</td>
</tr>
<tr>
<td>250.52</td>
<td>DM II, uncontrolled</td>
</tr>
<tr>
<td>250.53</td>
<td>DM I, uncontrolled</td>
</tr>
</tbody>
</table>
Diabetic Retinopathy

- In ICD-9, two codes must be reported for diabetic retinopathies.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>362.02</td>
<td>Diabetic retinopathy: proliferative diabetic retinopathy</td>
</tr>
<tr>
<td>362.03</td>
<td>Diabetic retinopathy: nonproliferative diabetic retinopathy NOS</td>
</tr>
<tr>
<td>362.04</td>
<td>Diabetic retinopathy: mild nonproliferative diabetic retinopathy</td>
</tr>
<tr>
<td>362.05</td>
<td>Diabetic retinopathy: moderate nonproliferative diabetic retinopathy</td>
</tr>
<tr>
<td>362.06</td>
<td>Diabetic retinopathy: severe nonproliferative diabetic retinopathy</td>
</tr>
<tr>
<td>362.07</td>
<td>Diabetic retinopathy: diabetic macular edema</td>
</tr>
</tbody>
</table>

In ICD-10 there are no longer two codes for diabetic retinopathies.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E10.31</td>
<td>Type 1 diabetes mellitus with unspecified diabetic retinopathy <strong>with</strong> macular edema</td>
</tr>
<tr>
<td>E10.31</td>
<td>Type 1 diabetes mellitus with unspecified diabetic retinopathy <strong>without</strong> macular edema</td>
</tr>
<tr>
<td>E10.32</td>
<td>Type 1 diabetes mellitus with <strong>mild</strong> nonproliferative diabetic retinopathy <strong>with</strong> macular edema</td>
</tr>
<tr>
<td>E10.32</td>
<td>Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy <strong>without</strong> macular edema</td>
</tr>
<tr>
<td>E10.33</td>
<td>Type 1 diabetes mellitus with <strong>moderate</strong> nonproliferative diabetic retinopathy <strong>with</strong> macular edema</td>
</tr>
<tr>
<td>E10.33</td>
<td>Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy <strong>without</strong> macular edema</td>
</tr>
</tbody>
</table>
## ICD-10 DM Type 1 w/ Eye Manifestation (2 of 2)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E10.341</td>
<td>Type 1 diabetes mellitus with <strong>severe nonproliferative</strong> diabetic retinopathy <strong>with</strong> macular edema</td>
</tr>
<tr>
<td>E10.349</td>
<td>Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy <strong>without</strong> macular edema</td>
</tr>
<tr>
<td>E10.351</td>
<td>Type 1 diabetes mellitus with <strong>proliferative diabetic</strong> retinopathy <strong>with</strong> macular edema</td>
</tr>
<tr>
<td>E10.359</td>
<td>Type 1 diabetes mellitus with proliferative diabetic retinopathy <strong>without</strong> macular edema</td>
</tr>
<tr>
<td>E10.36</td>
<td>Type 1 diabetes mellitus with <strong>diabetic cataract</strong></td>
</tr>
<tr>
<td>E10.39</td>
<td>Type 1 diabetes mellitus with <strong>other diabetic ophthalmic complication</strong></td>
</tr>
</tbody>
</table>
More on Diabetes and multiple codes

• These **additional coding instructions**, found in the ICD-10 manual, are what most look-up programs omit.

• **Use additional code** Z79.4 to indicate **insulin use** on the following diabetes codes:
  • **E09.*** Drug or chemical-induced diabetes
  • **E11.*** DM Type 2
  • **E13.*** Other specified diabetes

• **Code first the underlying condition; use additional code for adverse effects; use additional code for insulin use** (3 additional codes) for:
  • **E08 series**: Diabetes due to underlying condition.
ICD-10 Screening Codes

• Screening for long-term use of a high-risk drug (ICD-9: V58.69)
• Report Z79.899 for Plaquinil use for rheumatoid arthritis.
• Report M06.9 for rheumatoid arthritis, unspecified.
• Always report both; link to both, and if the carrier does not pay on the Z code, link to the M code first (or only link to the M code above).
• Once an adverse effect is found for Hydrochlorquine sulfate (Plaquenil), the ICD-9 code is: E931.4.
• The ICD-10 code is: T37.2X5A. Includes...Adverse effect of antimalariaals and drugs acting on other blood protozoa, initial encounter. Note there are the encounter codes (XA, XD and XS) Initial, Subsequent and Sequela.
Additional training is available

• The EyeCodingForum.com offers a comprehensive **six-hour ICD-10 Coding for Eyecare course.**
• It is recorded and can be viewed just like a video and paused or rewound at any time. It is a per clinic fee and videos can be watched any time until Oct 1 2015. It includes PowerPoint slides with narration.
• Visit the [www.EyeCodingForum.com](http://www.EyeCodingForum.com) website for more information on how we can help with all your ICD-9 to ICD-10 conversion needs.
• For more information contact [ecf@eyecodingforum.com](mailto:ecf@eyecodingforum.com) or call us at 901-517-1705.
Introduction to ICD-10 coding

Questions?

Jeffrey Restuccio, CPC, CPC-H, MBA
Memphis TN
(901) 517-1705
jeff@eyecodingforum.com
www.EyeCodingForum.com

Sponsored By: