Getting Ready for ICD-10

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Chart Documentation:

- Will your documentation stand up to ICD-10?
- Do you always mark which eye, severity or status of the disease (chronic or acute), site, etiology and any secondary disease process?
- Look at your current Impression/Plan. Are you currently documenting all of this information?
ICD-10 Includes:

- Increased site specificity.
- Laterality – RT, LT, or bilateral.
- Combination codes that capture:
  - Etiology and manifestation
  - Related conditions
  - Disease, injury or other medical complications
  - Diseases or other medical conditions and common signs or symptoms
ICD-10 Includes (cont’d):

- Increased specificity related to histologic behavior of certain neoplasms.
- Episode of care (initial, subsequent or sequela) for injuries, poisoning, external causes and other conditions.
- Increased specificity related to the type of injury.
- Intraoperative or post-procedural complications.
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Other ICD-10 Changes:

- Reclassification of codes into new categories or chapters. Eye and Adnexa H00-H59 is now its own chapter.
- A distinction is now made between intraoperative complications and postprocedural disorders. H59
- Updated terminology. Example: senile cataract is now referred to age-related cataract.
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Chapter 7: Disease of the Eye and Adnexa (H00-H59)

Chapter contains the following breakdown:

- H00-H05 Disorders of eyelid, lacrimal system and orbit
- H10-H11 Disorders of conjunctiva
- H15-H22 Disorders of sclera, cornea, iris and ciliary body
- H25-H28 Disorders of lens
- H30-H36 Disorders of choroid and retina
- H40-H42 Glaucoma
- H43-H44 Disorder of vitreous body and globe
- H46-H47 Disorder of optic nerve and visual pathway
- H49-H52 Disorder of ocular muscles, binocular movement, accommodation and refraction
- H53-H54 Visual disturbance and blindness
- H55-H57 Other disorder of eye and adnexa
- H59 Intraoperative and post-procedural complications and disorder of eye and adnexa, not elsewhere classified.
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General documentation include:

- Severity or status of the disease
- Site
- Etiology
- Secondary disease process
- Whether the complication was intraoperative or postoperative
- Upper or lower eyelid and laterality
Glaucoma

- Glaucoma has two categories:
  
  **H40 - Glaucoma specific to type**
  
  May require the 7th character
  
  0 - stage unspecified
  
  1 - Mild stage
  
  2 - Moderate stage
  
  3 - Severe stage
  
  4 - Indeterminate stage

  **H42 - Glaucoma in diseases classified elsewhere.**

  It does not require the 7th character and you must code the underlying condition first.
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Documenting Glaucoma

- Identify type of glaucoma.
- Identify the laterality.
- Identify the stage (stage is not always required. i.e.: suspect, residual stage, acute or intermittent angle closure…).
- If applicable, identify the drug and/or underlying condition.
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Chart example:

45 year old male 6m follow-up for ongoing glaucoma treatment. Diagnosed two years ago with *angle-closure glaucoma bilaterally*. Left eye progressed rapidly to *moderate* disease. Right eye difficult to determine. Both eyes appear to be stable at this time. No side effect from meds return in 6mo.

- **ICD-9 codes**
  - 365.23 Chronic angle closure glaucoma
  - 365.72 Moderate stage glaucoma

- **ICD-10 Codes**
  - H40.2222 Chronic angle closure glaucoma, left eye, moderate stage
  - H40.2214 Chronic angle closure glaucoma, right eye, Indeterminate stage
Cataract

- Two Categories:
  - Age Related
  - Other
    - Infantile and Juvenile
    - Traumatic
    - Complicated
    - Drug Induced
    - Secondary
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Documenting Cataract

- Identify the type of cataract
- Identify laterality
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Chart Example:
Nuclear cataracts bilaterally, OD is +2 and OS is +3.

- ICD-9 Code
  366.16 Nuclear sclerosis

- ICD-10 Code
  H25.13 Age-related nuclear cataract, bilateral
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Traumatic Cataract

- Total traumatic cataract left eye
  - H256.132

- Contusion of eyeball and orbital tissue, left eye
  - S05.12xA
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How to use the ICD-10-CM

Similar to ICD-9

• Codes are looked up in the same way, look up diagnostic terms in alphabetic index and then verify code in Tabular list.

Indexes

• Alphabetic index of disease and injuries
• Alphabetic index of external causes
• Table of neoplasms
• Table of drug and chemicals
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Tabular List

- Chronological list of codes divided into chapters based on body system or condition.
- Same hierarchical structure.
- Chapters in tabular similar to ICD-9
- Sense organs, eyes and ears have been separated from nervous systems. Now have their own chapters.
ICD-10 Specific:

- Codes are 3-7 characters long.
- The first character is alpha.
- The second character is numeric.
- Characters 3-7 are alpha or numeric.
- Decimal is used after the 3\textsuperscript{rd} character.
- The 1\textsuperscript{st} three characters = categories.
- Characters 4-6 = subcategories.
  - 4\textsuperscript{th} character further defines site, etiology, manifestation or state of disease or condition.
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ICD-10 Specific:

• 5<sup>th</sup> and 6<sup>th</sup> character increases specificity.
• 7<sup>th</sup> character = extension. Changes based on the code

Examples
A – initial encounter
B – subsequent encounter
S – sequela (late effect)

• X is used as a placeholder for future expansion and/or if a 7<sup>th</sup> character is needed.

H21.1x1 Vascular disorder of the right eye
H40.31x1 Glaucoma secondary to eye trauma, RT, mild stage
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Keratitis (nodular) (nonulcerative) (simple) (zonular)

H16.9
with ulceration (central) (marginal) (perforated) (ring)
— see Ulcer, cornea

H16 Keratitis

H16.0 Corneal ulcer

H16.00 Unspecified corneal ulcer

H16.001 Unspecified corneal ulcer, right eye
H16.002 Unspecified corneal ulcer, left eye
H16.003 Unspecified corneal ulcer, bilateral
H16.009 Unspecified corneal ulcer, unspecified eye

H16.01 Central corneal ulcer

H16.011 Central corneal ulcer, right eye
H16.012 Central corneal ulcer, left eye
H16.013 Central corneal ulcer, bilateral
H16.019 Central corneal ulcer, unspecified eye
Excludes 1
  - Indicates that code identified in the note and code where the note appears **cannot** be reported together because the 2 conditions cannot occur together.

Example: Type 1 Diabetes and Type 11 Diabetes

Pure excludes note means “not coded here”
Excludes 2-

- Indicates that the condition identified in the note is not part of the condition represented by the code where the note appears, so both codes may be reported together if the patient has both conditions.

Example: Hyphema can be billed with sympathetic uveitis (H21.0 with H44.1)

Excludes 2 represents “not included here”
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Terminology

- “and” – When used in a narrative statement, it represents **and/or**.
- Example: T26.11 – Burn of cornea and conjunctival sac, right eye.
- Example: S05.12xA - Contusion of eyeball and orbital tissue, left eye
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General Guidelines:

- Locate the code in the alpha or tabular list
- Code to the highest number of characters available.
- Can use codes for signs and symptoms when a definitive code has not been established.
- Use additional codes when stated.
- Acute and Chronic conditions - if present at the same visit use the acute code first.
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- Each “unique” diagnosis code can only be billed once during an encounter.
- Specify whether the code is RT, LT, or OU.
- Follow the alpha index guidance when coding syndromes.
- To code post op complications the complication must be documented in the patient’s chart.
  
  H59.021 (cataract fragments in OD following cataract surgery)