ICD-10 OPTHALMOLOGY

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IMPORTANCE OF DOCUMENTATION

- A significant portion of practice revenues, however, can be attributed to E&M services.
- Neglecting the proper documentation and coding of encounters is a common and costly mistake.
- If the coding for a service is incorrect at the outset, payment may be delayed, reduced, or not forthcoming at all.
- You also stand to increase revenues by learning to code correctly because as often as not, coding errors are "undercode" versus "overcode.“

CHANGES FROM ICD-9 TO ICD-10

- A significant change for ophthalmology is a chapter (chapter 7) devoted solely to diseases of the eye and adnexa.
- Chapter seven is an entirely new chapter in ICD-10-CM.
- In ICD-9, the sense organs (eye and ear) were included in the chapter on nervous conditions.
- Some categories in Chapter 7 have undergone title changes to reflect the terminology used today.
- In chapter 7, many conditions are listed as right eye, left eye, bilateral, or unspecified.
  in conformance with ICD-10 convention, postprocedural complications of eye surgeries are located in the eye chapter.

CHANGES FROM ICD-9 TO ICD-10 (CONT.)

- For certain diagnoses, ICD-10 also requires that a seventh digit representing the severity of the condition be coded as well, most notably glaucoma:
  - 1 represents mild disease;
  - 2 is moderate;
  - 3 is severe;
  - 0 is unspecified; and
  - 4 means it is indeterminate. -

ICD-10-CM

ICD-10 STRUCTURE & CONTENT

- ICD-10 diagnosis codes have between 3 and 7 characters
- Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of any or all of the 4th, 5th and 6th characters
- Digits 4-6 provide greater detail of etiology, anatomical site and severity
- A code using only the first three digits is to be used only if it is not further subdivided.
- Overall changes with ICD-10-CM:
  - Location
  - Laterality
  - Severity

VARYING CHANGES BY CLINICAL AREAS

Clinical Area	ICD-9 Code	ICD-10 Codes
Fracture's	747	17099
Poisoning and Toxic effects	244	4662
Pregnancy related conditions	1104	2155
Brain Injury	292	574
Diabetes	69	239
Migraine	40	44
Bleeding disorders	26	29
Mood related disorders	78	71
Hypertensive Disease	33	14
End stage renal disease	11	5
Chronic respiratory failure	7	4

ICD-10 BILLING AND CODING

- If you are a provider, then you will need to understand how ICD-10 requires specific documentation that differs from what was sufficient for ICD-9.

- If you are a coder, you must know how to translate the clinical information from the operative report into the ICD-10 system. One incorrect character and your entire claim will be undermined.

- When ICD-9 becomes ICD-10, your fracture codes explode with ultra specific options, meaning providers have to document extensive details to ensure the right diagnosis.

TERMINOLOGY CHANGES

- The word “and” has an unexpected meaning in ICD-10; it means “and/or.”
- The term "senile cataract" is replaced in ICD-10 with the term "age-related cataract."
- The term "nuclear sclerosis" is replaced with "age-related nuclear cataract."
- In ICD-10, "excludes" is used differently than in ICD-9 – and there are now two types:
  - Excludes1 notes indicate two medical conditions that can't be reported on the same eye the same day.
  - Excludes2 notes indicate two medical conditions that can be reported on the same eye the same day.

CLINICAL IMPACTS

CLINICAL DOCUMENTATION IMPACTS

- Quality clinical documentation is essential for communicating the intent of an encounter, confirming medical necessity, and providing detail to support ICD-10 code selection.
- Identifying the affected side is important, as some payers will not reimburse claims with “unspecified” codes.
- ICD-10-CM contains multiple combination codes so the documentation must reflect the association between conditions.
- Children’s conditions differ from those of adults therefore, accurate documentation of pediatric conditions is important for proper coding.
    - The accuracy of pediatric clinical documentation can have a great impact on many factors of children’s healthcare.

WITH ICD-10, APPROPRIATE CLINICAL DOCUMENTATION CAN

- Enhance communication and collaboration among providers and between physician and patient by filling in the gaps in treatment and care.
- Provide an accurate representation of the severity and complexity of a patients illness.
- Improve the quality of patient care, the patient care experience and strengthen the doctor-patient relationship.
- Connect the pieces of the medical record together for problems, assessments, procedures and treatments.
- Support and supplement provider documentation.
- Help substantiate the level of specificity required within ICD-10.
- Provides basis for specific services we provide.

ICD-10-CM EXAMPLES OF DOCUMENTATION SPECIFICITY

- New codes identifying abnormal findings separating routine preventative exams from exams that were clinically necessary for further investigation and assessment:

  Z00.121-Ecounter for routine child health examination with abnormal findings

  Z01.01-Encounter for examination of eyes and vision with abnormal findings

  Z01.31-Encounter for examination of blood pressure with abnormal findings

  Z01.411-Encounter for gynecological examination (general) (routine) with abnormal findings

- Chronic conditions (i.e. asthma, bronchitis, etc.) requires that any related tobacco use, abuse, dependence, past history or smoke exposure (e.g., second hand) be reported.

- More specific documentation regarding laterality and anatomical location is required to identify site for medicated dressings, splints, etc.

- Hearing loss is identified by laterality, rather than the location of the affected ear, delineate if hearing is different in both ears.

- Alzheimer's disease is distinguished as early onset or late onset

ICD-10 CLINICAL DOCUMENTATION IMPACTS

- Onset of care
- Etiology and Manifestation
- Anatomical site specificity
- Complications
- Laterality
- Combination Codes
- Disease severity
- Non-specific/unspecified

DOCUMENTATION REQUIREMENTS

VISUAL IMPAIRMENT

- This table gives a classification of severity of visual impairment recommended by a WHO Study Group on the Prevention of Blindness, Geneva, 6-10 November 1972. The term ‘low vision’ in category H54 comprises categories 1 and 2 of the table, the term ‘blindness’ categories 3, 4 and 5, and the term ‘unqualified visual loss’, category 9. If the extent of the visual field is taken into account patients with a field no greater than 10 but greater than 5 around central fixation should be placed in category 3 and patients with a field no greater than5 around central fixation should be placed in category 4, even if the central acuity is not impaired.

Category of visual Impairment	Visual acuity with best possible correction	
	Maximum less than:	Minimum equal to or better than:
	6/18	6/60
3/10(0.3)	1/10(0.1)	
20/70	20/200	
	6/60	3/60
1/10(0.1)	1/20(0.05)	
20/200	20/400	
	3/60	1/60(finger counting at one meter
1/20(0.05)	1/50(0.02)	
20/400	5/300(20/1200)	
	1/60(finger counting at one meter)	Light perception
1/50(0.02)		
5/300		
	No light perception	
	Undetermind or unspecified	

GLAUCOMA

Assigning Glaucoma Codes

- Assign as many codes from category H40, Glaucoma, as needed to identify the type of glaucoma, the affected eye, and the glaucoma stage.
  - 0-stage unspecified (only to be used when there is no documentation regarding the stage of glaucoma)
  - 1-mild stage
  - 2-moderate stage
  - 3-severe stage
  - 4-indeterminate stage (only used for glaucomas whose stage cannot be clinically determined, should not be confused with seventh character “0”)

Bilateral glaucoma with same type and stage

- When a patient has bilateral glaucoma and both eyes are documented as being the same type and stage, and there is a code for bilateral glaucoma, report only the type for the type of glaucoma, bilateral, with the seventh character for the stage.

- When a patient has bilateral glaucoma and both eyes are documented as being the same type and stage, and the classification does not provide a code for bilateral glaucoma (i.e. subcategories H40.10, H40.11 and H40.20) report only one code for the type of glaucoma with the appropriate seventh character for the stage.

GLAUCOMA (cont.)

Bilateral glaucoma stage with different types or stages

- When a patient has bilateral glaucoma and each eye is documented as having a different type or stage, and the classification distinguishes laterality, assign the appropriate code for each eye rather than the code for bilateral glaucoma.

- When a patient has bilateral glaucoma and each eye is documented as having a different type, and the classification does not distinguish laterality (i.e. subcategories H40.10, H40.11 and H40.20), assign one code for each type of glaucoma with the appropriate seventh character for the stage.

- When a patient has bilateral glaucoma and each eye is documented as having the same type but different stage, and the classification does not distinguish laterality i.e. subcategories H401.10, H40.11 and H40.20), assign a code for the type of glaucoma for each eye with the seventh character for the specific glaucoma stage documented for each eye.

GLAUCOMA (cont.)

Patient admitted with glaucoma and stage evolves during the admission

- If a patient is admitted with glaucoma and the stage progresses during the admission, assign the code for the highest stage documented.

Indeterminate stage glaucoma

- Assignment of the seventh character “4” for “indeterminate stage” should be based on the clinical documentation.

- The seventh character “4” is used for glaucoma whose stage cannot be clinically determined.

- This seventh character should not be confused with the seventh character “0”, unspecified, which should be assigned when there is no documentation regarding the stage of the glaucoma.

GLAUCOMA (cont.)

Bilateral glaucoma stage with different types or stages

- When a patient has bilateral glaucoma and each eye is documented as having a different type or stage, and the classification distinguishes laterality, assign the appropriate code for each eye rather than the code for bilateral glaucoma.

- When a patient has bilateral glaucoma and each eye is documented as having a different type, and the classification does not distinguish laterality (i.e. subcategories H40.10, H40.11 and H40.20), assign one code for each type of glaucoma with the appropriate seventh character for the stage.

- When a patient has bilateral glaucoma and each eye is documented as having the same type but different stage, and the classification does not distinguish laterality i.e. subcategories H401.10, H40.11 and H40.20), assign a code for the type of glaucoma for each eye with the seventh character for the specific glaucoma stage documented for each eye.

CATARACTS

- To code for cataracts, the documentation must first specify the type of age-related cataract:
  - combined form,
  - incipient (cortical, anterior subcapsular, posterior subcapsular polar, other incipient type),
  - nuclear, morgagnian, other specified type, or unspecified type.

- There are codes for infantile and juvenile cataracts, traumatic cataracts, drug-induced cataracts, and secondary cataracts.

- All cataract codes indicate right, left, bilateral, and unspecified, and the documentation must identify which eye (or both) is involved.

DIABETES

- In ICD-10 ophthalmic diabetic manifestations are now one **combination code** instead of two codes in ICD-9.
- Documentation should be consistent with current practices
- State if hypoglycemia results in coma
- Identify when diabetes is accompanied by hyperglycemia or hypoglycemia
- ICD-10 no longer includes the concept of “Uncontrolled”
- ICD-10-CM codes for diabetes are combination codes that include the etiology and the manifestations
- In ICD-10 diabetes include notes appear at the beginning of a category
- The “Excludes1” note meaning “Not coded here” appears under all the diabetes categories

DIABETES

- Documentation and coding will need to include the following:
  - Type or cause of diabetes
    - Type 1 or 2
    - Due to drugs or chemicals
    - Due to underlying condition
    - Other specified diabetes
  - Any complications or manifestations
  - Current treatment

- If there are complications/manifestations of the diabetes, additional details may be necessary for specific complications such as:
  - Arthropathy
  - Site of ulcer
  - Severity of retinopathy
  - With/without macular edema
  - Stage of CKD
  - Gangrene
  - Hypoglycemia

ROUTINE EYE EXAMS

- "Routine exam of eyes" code (V72.0) changes to two codes with ICD-10:
  - 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.

DOCUMENTATION CHANGES AND NEW CONCETPS

DOCUMENTATION CHANGES

- It is vital for physicians, nurses, and coders to work together to create an environment of increased accuracy.
- With the increased number and specificity of codes under ICD-10, physicians are going to have to be more specific in their patient encounter documentation to provide the coders the best opportunity to choose the most correct codes for the most appropriate reimbursement.
- Physicians and other clinicians likely already note laterality when evaluating the clinically pertinent anatomical site(s).
- Physicians will be judged on documentation more critically in ICD-10.

DOCUMENTING UNDERDOSING

- Underdosing is an important new concept and term in ICD-10. It allows you to identify when a patient is taking less of a medication than is prescribed
- When documenting underdosing, include the following:
  1. Intentional, Unintentional, Non-compliance

  Is the underdosing deliberate? (e.g., patient refusal)

  2. Reason

  Why is the patient not taking medications? (e.g., financial hardship, age-related disability?)

T38.3X6A-Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, initial encounter
T38.3X6D-Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, subsequent encounter
T38.3X6S-Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, sequelae

Z91.120-Patient's intentional underdosing of medication regimen due to financial hardship
Z91.128-Patient's intentional underdosing of medication regimen for other reason
Z91.130-Patient's unintentional underdosing of medication regimen due to age-related debility
Z91.138-Patient's unintentional underdosing of medication regimen for other reason

CODING SUPPORTS THE PATIENT STORY

- The primary code is the main reason for the visit
  - Ensure that the primary code is an appropriate primary code as defined in the guidelines

- Additional codes should be reported where required by coding conventions (“code also”, “use additional code”)

- Document conditions that may add complexity to treatment such as cerebral palsy, seizure disorders, autism, multiple sclerosis

- Avoid “over-coding” – if it isn't relative to the visit, don’t code it

CONTACTS

If you have any questions or concerns about the information presented here, please contact Shannon Chase or Mary Ellen Reardon and we will be glad to assist you.

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Thank You