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Five Glaucoma Tips for ICD-10

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Staging or no staging? Laterality or no laterality? Finding the appropriate ICD-10 code for a glaucoma diagnosis can initially seem overwhelming, but you can simplify the task by considering these five tips.

Tip 1—Laterality and staging. Not all codes have laterality. Not all codes require staging. When laterality is required, you usually report it in the code's sixth position (e.g., H40.03-)—very occasionally in the fifth position (e.g., H46.0-)—using the following:

- 1 for the right eye
- 2 for the left
- 3 for both

When staging is required, report it in the code's seventh position (e.g., H40.141-), using the following:

- 0 for stage unspecified
- 1 for mild
- 2 for moderate
- 3 for severe
- 4 for indeterminate

Example: Staging with laterality. H40.2213 is the code for chronic angle-closure glaucoma in the right eye, severe stage, with the sixth position indicating laterality (1 for right eye) and the seventh position indicating stage (3 for severe stage).

Example: Staging without laterality. H40.11X3 is the code for primary open-angle glaucoma (POAG), severe stage. Why the X? The POAG codes require a staging indicator, which must go in the seventh position. However, the POAG codes don't have laterality, which means there is no laterality indicator to fill the sixth position—instead, you use an X as a placeholder.

Tip 2—If no laterality. When a diagnosis code does not have laterality, you should code the eye with the more severe stage of glaucoma.

Tip 3—Link to the CPT code. As with ICD-9, you must link the appropriate ICD-10 code to the specific CPT code. This step is just as critical as it was with ICD-9.

Example: CPT code 92133. When you report CPT code 92133—which is the code for scanning computerized ophthalmic diagnostic imaging (SCODI)—you can choose from more than 150 glaucoma-related ICD-10 codes, ranging from H21.551 *Recession of chamber angle, right eye* to Q15.0 *Congenital glaucoma.* (To download a handy cheat sheet of glaucoma-related ICD-10 codes that support the use of SCODI, go to this article online at www.eyenet.org.)

If your Medicare contractor has issued a Local Coverage Determination (LCD) that applies to the CPT code you're linking to, make sure you check that LCD for any special instructions. For instance, one LCD says "SCODI would rarely be necessary or beneficial with patients who have advanced optic nerve damage." The same LCD also states, "It is expected that only two (SCODI) exams/eye/year would be required to manage the patient who has glaucoma or is suspected of having glaucoma." But LCDs on SCODI vary, and it is important to be familiar with the one that applies in your state.

Tip 4—Watch for Excludes1 notes. These flag diagnosis codes that can't be reported in the same eye at the same time.

Example: H40.06. The code for primary angle closure without glaucoma damage (H40.06-) is covered by an Excludes1 note. This indicates that if you report H40.06-, you can't also report absolute glaucoma (H44.51-), congenital glaucoma (Q15.0), or traumatic glaucoma due to birth injury (P15.3) for the same eye on the same day.

Tip 5—Use the ICD-10 reference guide. See the *Glaucoma Quick Reference Guide* that was jointly developed by the American Glaucoma Society, the Academy, and the American Academy of Ophthalmic Executives. It is available online: Go to www.aao.org, click "Practice Management," then click "Coding," and select "ICD-10-CM" from the drop-down menu. ■

Quick Guide to ICD-10

Visit www.eyenet.org/archive for a primer (Practice Perfect, March) and for tips on cataract (Savvy Coder, April) and retina (Savvy Coder, May).