TROUBLESHOOTING THE 7TH CHARACTER

A primer on using A, D, and S characters in ICD-10-CM vitreoretinal coding.

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Most of the codes in ICD-10-CM Chapter 19 (Injury, Poisoning, and Certain Other Consequences of External Causes, S00-T88) contain instructions to use A, D, or S as the 7th character in the diagnosis code sequence. The necessity of using one of these characters occurs with some frequency in vitreoretinal coding. This month's review focuses on their application for diagnosis coding of services and procedures found in a retinal practice and provides guidance for their use. The Centers for Medicare and Medicaid Services (CMS) provides continuing education on this. The CMS website and YouTube channel are good sources of definitive information.[1,2]

CHARACTERISTICS OF 7TH CHARACTER A, D, OR S CODES

A, D, and S codes are defined as follows: A = initial encounter; D = subsequent encounter; S = sequela. Codes in ICD-10-CM may have a varying number of characters containing an alphanumeric mixture. For example, code S05.51 (penetrating wound of orbit with foreign body of right eyeball) contains five characters but requires an A, D, or S as the 7th character, which must be positioned as such. If the selected code has five characters, then one uses an x placeholder in the sixth position so that the A, D, or S falls into the seventh position (eg, S05.51xA). Note: An x can be used to hold the place of any number of characters in order to meet the seven-character requirement.

Different publishers use different methods of signifying the requirement in the ICD-10-CM books. In the version published by the American Medical Association, a rose-colored box appears, as below.[3]

> The appropriate 7th character is to be added to each code from category S05
> A initial encounter
> D subsequent encounter
> S sequela

> **"The character A, when mandated in the seventh position, is to be used as long as the patient is receiving active care for the condition.**

In comparison, Practice Management Information Corporation's version uses ⊗ and Ⓣ in front of each code to indicate that a placeholder X or 7th character is required.[4] Example: ⊗Ⓣ S05.51 (meaning you should use S05.51xA).

More pointers on using the 7th character codes:

- Different types of 7th character codes exist. For example, in addition to those discussed in this article (A, D, and S), there are completely different 7th character codes for glaucoma staging and for fractures. The only thing that they all have in common is the rule that they must appear in the seventh position.
- The x placeholder may be a lowercase or uppercase letter.
- If the diagnosis code chosen requires a 7th character but one is not used, then the code is considered invalid and your claim will be rejected.

USAGE OF THE 7TH CHARACTER A: INITIAL ENCOUNTER

The character A, when mandated in the seventh position, is to be used as long as the patient is receiving active care for the condition. The key word is active, and A should be used regardless of provider as long as the patient is receiving active treatment (medical or surgical) for the condition.

The word *initial* has caused some confusion because the usage is different from how most coders have been trained for its use in the Current Procedural Terminology (CPT). The latest instructions from CMS are to disregard the word *initial* and use A as long as the patient is still receiving

active treatment for the condition described by the code.

In CPT, for example, an initial encounter for an office consultation is the first time the patient is examined for that condition, and a subsequent encounter would become an office visit for an established patient. Another example is the use of *initial* and *subsequent* for extended ophthalmoscopy. CPT code 92225 is initial, meaning that it is used the first time the provider is performing extended ophthalmoscopy for that specific condition. CPT code 92226 is subsequent, meaning that the code should be used for follow-up examinations for the same condition.

Here are some pointers on using A in the seventh position:

- Whether or not a new or different provider is examining the patient is irrelevant for determining the 7th character; rather, the determination is based solely on whether active treatment for the condition is being provided.
- When a complication, such as an infection, occurs in the postoperative period, active treatment refers to treatment of the condition described by the code, even though the condition may be related to an earlier precipitating problem. If the selected diagnosis code requires a 7th character, then one would still use A because active treatment is being provided.
- Multiple providers and sites may use a diagnosis with A as the 7th character as demonstrated in Case 1.

CASE STUDIES: A AND D AS THE 7TH CHARACTER

The following case studies demonstrate use of A and D characters in ICD-10 vitreoretinal coding.

Case No. 1

History

Patient with severe ocular trauma to his left eye (OS) stated that broken glass had flown into his eye (no further information was given in the operative note). He was examined in the emergency department (ED), and a determination was made that he had sustained a corneal laceration with a foreign body OS. The diagnosis used by the ED was S05.52xA. An ophthalmologist was called to the ED to examine the patient. She also used S05.52xA for her diagnosis as well as diagnoses two and three (listed below). She referred the patient to a retina specialist who performed surgery as indicated below using the same three diagnoses.

Surgery

Preoperative evaluation revealed a full thickness corneal laceration, traumatic cataract, posteriorly located retained intraocular foreign body, and vitreous hemorrhage. Surgery consisted of removal of glass foreign body located on the posterior aspect of the retina using forceps; pars plana vitrectomy (PPV) with endolaser and cryopexy; lensectomy for removal of traumatic cataract; repair of full thickness corneal laceration without uveal repositioning; and anterior mechanical vitrectomy for removal of vitreous in anterior chamber.

When the retina specialist examined the patient for follow-up 100 days after surgery, he would be still considered in active treatment (medical, perhaps, at that point), and S05.52xA would be used. However, the plan was to return for a checkup, and, because the patient was no longer receiving active treatment at the subsequent visits, the diagnosis code would be S05.52xD.

Diagnosis Codes

1. S05.52xA Penetrating wound with foreign body, left eye
2. H26.102 Traumatic cataract, left eye
3. S05.32xA Ocular laceration without prolapse or loss of intraocular tissue, left eye

CPT CODE	MODIFIERS	ICD-10-CM CODE(S)
65265 Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction	-LT	1
67039 Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation	-51-LT	1
66850 Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacofragmentation), with aspiration	-51-LT	2
65280 Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue	-51-LT	3

Tips

- For further comments on this case, see the coding column from the January/February 2016 issue of *Retina Today* issue.[5]
- Note that all places of service and providers used the same diagnosis with A as the 7th character because active treatment for the condition was being provided—except at the final visit.
- Because there is no other information on how the glass got in the patient's eye, it is not possible to provide an external cause (from Chapter 20), even though it might be desirable in this case. In any event, external causes are not required for the case codes to be considered valid.

Case No. 2

History

A patient presented with a rhegmatogenous retinal detachment with a horseshoe break superotemporally and a round break superonasally. The patient was pseudophakic, and the intraocular lens became displaced during the repair procedure. Surgery consisted of PPV repair of the retinal detachment with air-fluid exchange, cryopexy, endolaser photocoagulation, and repositioning of the intraocular lens using a Sinskey hook.

Diagnosis Codes

1. H33.021 Retinal detachment with multiple breaks, right eye
2. T85.22xA Displacement of intraocular lens
3. Z98.89 Personal history of surgery

CPT CODE	MODIFIERS	ICD-10-CM CODE(S)
67108 Repair of complex retinal detachment by vitrectomy, etc.	RT	1
66825 Repositioning of intraocular lens prosthesis, requiring an incision	-51-RT	2, 3

Tip

- The A is used as the 7th character because the displacement of the lens was iatrogenically induced and the patient received active treatment.

USAGE OF THE 7TH CHARACTER D: SUBSEQUENT ENCOUNTER(S)

Following the same rules for placement in the seventh position, use D when the diagnosis selected is no longer for treating an active condition but rather for follow-up. Although the follow-up in this sense is often referred to as routine care, do not use this wording, as it may lead Medicare to consider the service medically unnecessary.

D is essentially used when the patient is no longer under active care for his or her condition and is receiving ordinary follow-up care during the healing or recovery phase. Examples of usage might include follow-up diagnostic testing to assess condition of the eye, suture removal, medication adjustment, follow-up visits to assess healing status (does not have to be same provider), and other aftercare. Again, D only has to be used when the selected diagnosis requires a 7th character.

USAGE OF THE 7TH CHARACTER S: SEQUELA

Sequelae (late effects and/or complications) are conditions that occur as a direct result of an acute condition.

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Scar contracture after a burn is a nonophthalmic example that is easily understood. If the diagnosis is related to disease progression and not specifically to trauma or injury, then it is not necessary to use diagnoses from Chapter 19 that require the 7th character.

Any complication resulting from the acute condition should be coded with the 7th character and not with Z codes, which are used for aftercare (eg, Z98.89–Personal history of surgery). In this context it is critical to differentiate a late complication that eventually requires treatment (eg, scarring from prior surgery or treating scars after burns) from a complication that is more immediate and requires active treatment such as endophthalmitis after an intravitreal injection. In these types of occurrences, A should be used rather than S when the chosen diagnosis code requires a 7th character.

An example is the development of proliferative vitreoretinopathy occurring after primary repair of a rhegmatogenous retinal detachment. When the patient presents, a code from Chapter 7 (Diseases of the Eye and Adnexa), such as H33.41 Traction detachment of retina right eye, may be selected. It is not necessary to use a diagnosis code requiring a 7th character or a Z code. You will find more use for A and D than for S. ■

1. Centers for Medicare and Medicaid Services. www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html. Medicare fee-for-service provider resources. December 9, 2015. Accessed February 2, 2016.
2. Centers for Medicare and Medicaid Services. www.youtube.com/watch?v=Mv2BiBccEcU. ICD-10 Post-Implementation: Coding Basics Revisited. December 8, 2015. Accessed February 2, 2016.
3. *ICD-10-CM: The Complete Official Codebook*. Chicago, IL: American Medical Association; 2016.
4. Centers for Disease Control and Prevention. www.cdc.gov/nchs/icd/icd10cm.htm. International classification of diseases, tenth revision, clinical modification (ICD-10-CM). 2015. Accessed February 2, 2016.
5. Asbell RL. Updates for retina coding: 2016. *Retina Today*. 2016;11(1):28-30.

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