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Central Retinal Vein Occlusion

At Healthfirst, we are committed to helping providers accurately document and code their patients' health records. This tip sheet is intended to assist providers and coding staff with the documentation and ICD-10-CM selection of services submitted to Healthfirst specifically for common types of **Central Retinal Vein Occlusion**. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Coverage decisions are based on the terms of the applicable evidence of coverage and the provider's participation agreement. This includes the determination of any amount that Healthfirst or the member owes the provider.

Central retinal vein occlusion is a condition in which the main vein that drains blood from the retina closes off partially or completely.

Diagnosis Codes and Descriptions

One of the following (*) 7th characters is to be assigned to codes in subcategory H34.81 to designate the severity of the occlusion: (**0-With macular edema; 1-With retinal neovascularization; 2-Stable (Old central retinal vein occlusion**)

ICD-10-CM	Descriptions
H34.811*	Central retinal vein occlusion, right eye
H34.812*	Central retinal vein occlusion, left eye
H34.813*	Central retinal vein occlusion, bilateral

*Requires additional digits to complete the code.

Documentation Recommendations

Updated Status of Condition	• Stable • Worsening • Improved • Range of vision changes
Specify Severity	• With macular edema • With retinal neovascularization • Stable (Old central retinal vein occlusion)
Type	• Non-ischemic • Ischemic
Laterality	• Right eye • Left eye • Bilateral
Identify Risk Factors	• i.e. Hypertension, Diabetes Mellitus, Smoking, Embolism • History of strokes or ministrokes
Link Associated Conditions with Terms	• “Due to,” • “Secondary to” or • “Associated with”
Treatment Plan	• Medications. i.e. Timolol and Acetazolamide • Reduction of intraocular pressure • Surgical or Laser mediated embolectomy. • Anti-VEGF injections • Steroid injection

Coding Tips

- Use an external cause code following the code for the eye condition, if applicable, to identify the cause of the eye condition.
- **Do not** use diabetes mellitus related eye conditions.
- **Do not** use words that imply uncertainty ("likely," "probable," "apparently," "consistent with," etc.) to describe a current or confirmed diagnosis in the outpatient setting.

Coding Example

Case	A new patient presents with blurred vision and pain in bilateral eyes. The ophthalmologist examines the retina using optical coherence tomography (OCT) and fluorescein angiography, which **shows central retinal vein occlusion with macular edema and abnormal blood vessel formation in the right eye**. The patient received an Anti-VEGF injection. What code should the ophthalmologist report?
Incorrect ICD-10-CM	**H34.8130**, Central retinal vein occlusion, bilateral
Correct ICD-10-CM	**H34.8110**, Central retinal vein occlusion, right eye
Rationale	Provider documentation states "patient has central retinal vein occlusion with macular edema in right eye." Central retinal vein occlusion is not specified as bilateral eye, ICD-10 code **H34.8110** is most appropriate.

References

- Coding Clinic
- ICD-10-CM Guidelines FY25 October 1 2024
- Case Definitions: Other Eye Disorders | Vision and Eye Health Surveillance System | CDC
- Central Retinal Artery Occlusion and Branch Retinal Artery Occlusion | Merck Manuals

Questions?

Contact us at #Risk_Adjustments_and_clinical_Documentation@healthfirst.org.

For additional documentation and coding guidance, please visit the coding section on HFproviders.org