Codify
BY AAPC

Pain Management Coding Alert

Reader Question: Get Familiar With 'Unspecified' and 'Other Specified' ICD-10 Terms

Question: I have seen lots of great ICD-9 to ICD-10 crosswalks, but it seems like there are some codes that don't have a bridge between the current system and the new one. Is that the case?

Montana Subscriber

Answer: The answer, unfortunately, is yes, there are some codes that do not have a direct crosswalk between the ICD-9 system and ICD-10, which will take effect on Oct. 1, 2015.

"There are instances where there is not a translation between an ICD-9-CM code and an ICD-10 code," CMS says on its website. "Examples include ICD-10-CM code Y71.3 (Surgical instruments, materials and cardiovascular devices [including sutures] associated with adverse incidents), which has no reasonable translation in ICD-9-CM; and ICD-9-CM procedure code 89.8 (Autopsy), which has no reasonable translation in ICD-10-Procedure Coding System."

Beware: As you know, ICD-9 does not advise you to "code close" to a diagnosis code, and ICD-10 won't either. If you can't find an applicable code in ICD-10 that describes your patient's condition, you'll be forced to use an "other" or "unspecified" code and then explain the situation to your MAC if necessary. Reporting an ICD-10 code that's "close" to your patient's condition does everyone a disservice because it brands that patient with a condition he never had, and looks suspicious to auditors who might think you're picking diagnosis codes that get the claim paid but don't actually match the documentation.

In black and white: "Codes titled 'other' or 'other specified' are for use when the information in the medical record provides detail for which a specific code does not exist," the Centers for Disease Control & Prevention says in its ICD-10-CM Official Guidelines for Coding and Reporting, updated earlier this year. "Codes titled 'unspecified' are for use when the information in the medical record is insufficient to assign a more specific code."

In other words, you'll use an "other specified" code when the doctor is specific in the record but no applicable code exists, and you'll use an "unspecified" code when the physician does not provide you enough information to pinpoint the correct ICD-10 code.