Codify
BY AAPC

Pain Management Coding Alert

Reader questions: Search for the Most Definitive Diagnosis, Even With ICD-10

Question: Though there are many crosswalks from ICD-9 to ICD-10, there are many codes that do not have a direct match. Will ICD-10 also offer "other" or "other specified" choices for conditions that have no definitive codes described?

Montana Subscriber

Answer: When ICD-10 goes into effect on Oct. 1, 2015, you will see that not all codes in ICD-9 have a direct crosswalk to ICD-10 codes. "There are instances where there is not a translation between an ICD-9-CM code and an ICD-10 code," CMS states 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."

What you'll do: As you know, ICD-9 does not advise you to "code close" to a diagnosis code, and ICD-10 won't either. ICD-10 guidelines state, "Codes that describe signs and symptoms, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider." If you can't find an applicable code in ICD-10 that describes the 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 is not advisable. If you do so, you actually report a condition that the patient never had. You can only invite audits by adopting this practice. This is because your claims will not match the documentation that you can potentially submit.

Check for definitive options: "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 and Prevention states in its most recent update of ICD-10-CM Official Guidelines for Coding and Reporting. "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.