Stop Using "Unspecified" ICD-10 Codes

Don't open yourself up to an unnecessary audit.

BY JEFFREY LEHRMAN, DPM

On claim forms, and in other documents, providers indicate the diagnosis that was addressed using a code from the International Statistical Classification of Diseases and Related Health Problems (ICD). This list is maintained by the World Health Organization (WHO). The 10th revision of the list (ICD-10) was endorsed in 1990 and first used in 1994. In the United States, diagnosis codes are listed in the ICD-10 Clinical Modification (ICD10-CM), developed and maintained by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). The United States transitioned from the previous revision of ICD, ICD9-CM, to ICD10-CM on October 1, 2015.

When this change occurred, thousands of new "unspecified" ICD10-CM codes were introduced. In most cases, it is inappropriate to use these "unspecified" ICD10-CM codes. However, over five years after the introduction of ICD10-CM in the United States, there are still too many providers using "unspecified" ICD10-CM codes. As time goes on, the use of these codes is leading to more problems and increased payment denials. It is time to stop using these codes.

Why It Is Wrong

For many pathologies listed in ICD10-CM, additional characters added to the base code add specificity and are required. Use of an "unspecified" ICD10-CM code normally indicates that the documentation did not contain the information needed to select the appropriately specific code. For example, the ICD10-CM code options for hallux valgus (acquired) include:

M20.10—Hallux valgus (acquired), unspecified foot

M20.11—Hallux valgus (acquired), right foot

M20.12—Hallux valgus (acquired), left foot

When considering these options, a selection of M20.10 would indicate that the documentation did not specify whether the pathology involved the right foot or left foot. In this case, the use of an "unspecified" ICD10-CM code would indicate to a third party payer that the documentation was incomplete and did not "specify" what it should have in order to select a more specific diagnosis code. Using this example, if the documentation did, in fact, specify whether the right or left foot was involved, it would be inappropriate to choose an ICD10-CM code which indicated that right versus left designation was left "unspecified" in the documentation.

In most cases, it is inappropriate to use "unspecified" ICD10-CM codes.

Another example can be found in the ICD10-CM coding for a diabetic foot ulcer. Among other required ICD10-CM codes, the L97- ICD10-CM code options for a left plantar heel diabetic foot ulcer whose deepest depth of tissue exposed is subcutaneous tissue include:

L97.421 Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin

L97.422 Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed

L97.423 Non-pressure chronic ulcer of left heel and midfoot with necrosis of muscle

L97.424 Non-pressure chronic ulcer of left heel and midfoot with necrosis of bone

L97.425 Non-pressure chronic ulcer of left heel and midfoot with muscle involvement without evidence of necrosis

L97.426 Non-pressure chronic ulcer of left heel and midfoot with bone involvement without evidence of necrosis

L97.428 Non-pressure chronic ulcer of left heel and midfoot with other specified severity

L97.429 Non-pressure chronic ulcer of left heel and midfoot with unspecified severity

If the documentation of this ulcer were thoroughly and properly performed, it would include the fact that the deepest depth of tissue exposed is subcutaneous tissue. Selecting L97.429 would indicate that the documentation was incomplete and did not specify the severity of the ulcer. The more appropriate selection in

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this example is L97.422, reflecting the thorough documentation that did, in fact, specify the depth of the ulcer.

"Other" Is Okay

Do not make the mistake of treating "other" ICD10-CM codes the same as "unspecified" ICD10-CM codes. Whereas this article points out that it is rarely appropriate to use "unspecified" ICD10-CM codes, there are often occasions where the use of an "other" ICD10-CM code is correct. This would be the case when the complete information needed is specified in the documentation, but the ICD10-CM code options do not include the option needed for the highest level of specificity. A common example encountered in podiatric medicine involves sprain of an ankle ligament. The ICD10-CM code options for this are:

S93.40—Sprain of unspecified ligament

S93.41—Sprain of calcaneofibular ligament

S93.42—Sprain of deltoid ligament

S93.43—Sprain of tibiofibular ligament

S93.49—Sprain of other ligament of ankle

Among these examples, the only named ligaments that are specified are calcaneofibular ligament, deltoid ligament, and tibiofibular ligament. The option missing from this list is the ankle ligament most often involved in an ankle sprain, the anterior talofibular ligament. If the documentation specified that the ligament sprained was the anterior talofibular ligament, this would be an example of knowing which specific ligament was involved, specifying that information in the documentation, then not seeing that as an option in the ICD10-CM code set. Selecting the S93.49- code would indicate that the provider knew which ligament was involved, specified which ligament was involved in the documentation, but that ligament was not among those listed in the ICD10-CM code options. In this scenario, selecting S93.40 would be incorrect as it would indicate that the ligament that was involved was left "unspecified" in the documentation when it, in fact, was clearly specified as the anterior talofibular ligament.

Do not make the mistake of treating "other" ICD10-CM codes the same as "unspecified" ICD10-CM codes.

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Why This Is a Problem

Incorrect ICD10-CM coding can be problematic in the case of an audit performed by a third party payer or its representative. If the documentation specified what it should, but the ICD10-CM code selected indicates this specification was not present, a case for incorrect coding could be made. Furthermore, as more time passes since the transition from ICD-9-CM to ICD10-CM, more and more third party payers are denying payment for services submitted with "unspecified" ICD10 codes. For example, Noridian Healthcare Solutions, LLC, the Part B Medicare Administrative Contractor with more states than any other in the country under its jurisdiction, is, at the time of this report, removing most "unspecified" diagnosis codes from its Billing and Coding Local Coverage Articles.

Exceptions

There are rare exceptions where it may be appropriate to use an "unspecified" ICD10-CM code. This may occur when the steps needed to pick a more precise code have not yet occurred. For example, a podiatrist may be the first to diagnose a patient with peripheral vascular disease by detecting non-palpable pedal pulses bilaterally. This exam finding may be enough to diagnose the patient with peripheral vascular disease, but not be enough to specify the nature of the peripheral vascular disease. With many different potential types of this peripheral vascular disease, a more specific ICD10-CM code cannot be selected until a more involved evaluation is performed and the disease is better characterized. Until the specificity of the peripheral vascular disease is identified, I73.9 (Peripheral vascular disease, unspecified) remains the most appropriate code.

Conclusion

In most cases, it is best to avoid "unspecified" ICD10-CM codes. Most of the time, use of "unspecified" ICD10-CM codes indicates to a third party payer that the documentation was incomplete and did not "specify" what it should have in order to select a more precise diagnosis code. As more time passes since the adoption of ICD10-CM in the United States, more third party payers are not paying claims where "unspecified" ICD10-CM codes are used. **PM**

Reference

CMS.GOV 2021 ICD-10 CM files—https://www.cms.gov/medicare/icd-10/2021-icd-10-cm

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