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Dealing with Unspecified Codes

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Q: How or when or do I use unspecified and other diagnosis codes in ICD10? I am confused when it comes to using codes that state unspecified. I see there are three codes for extremity pain codes. There is a code for right, left and unspecified. I have heard from some that I should never use the code unspecified, is that correct?

A: With the plethora of new codes available in ICD10, some of the language can be overwhelming, or at best, confusing to decipher. In fact, that statement is partially true. Indeed, it is not likely you would ever use a code for an unspecified shoulder. However, let's make a clarification of this meaning. The code M25.519 indicates pain in the unspecified shoulder, while M25.511 is pain in the right shoulder and M25.512 is pain in the left shoulder. When you physically examine the patient, it would be clear that you could identify the pain being right, left or both shoulders. Therefore, it would not be appropriate to indicate unspecified shoulder as you can identify if it is right, left or both. In this instance, the statement of not using unspecified would be correct.

Please note do not infer that unspecified may or does mean both or bilateral. If both shoulders have pain, the claim would indicate both the right and left codes. For pain in the extremities, there is no code that indicates bilateral and therefore, when right and left are involved, both codes would be utilized. Unspecified shoulder would likely only be used in a setting such as a hospital where emergency personnel contact the hospital indicating a shoulder injury and the initial documentation of the diagnosis would be unspecified until the person is examined.

However, there are many codes that indicate unspecified or other and are not referring to left, right or location. When using codes that state "other" or "unspecified," note these have special meanings. 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. One obvious example is muscle spasm. There are three codes that indicates muscle spasm, muscle spasm of the back is M62.830 and muscle spasm of the calf is M62.831 which are specific to those two regions. But a third code is M62.838 other muscle spasm. The "other" code would be chosen when the spasm is not in the back or the calf but some "other" region.

Another example would be a patient where the history and exam findings lead you to a diagnosis of facet syndrome. When you search, there is no specific code that states "facet syndrome." In this case, you would use the codes M53.80 to M53.88 which are noted as "other specified dorsopathies." These codes define and extend from the occipito-atlanto-axial region to the sacral and sacrococcygeal region. This would be the proper code to use when specifying the condition as "facet syndrome" and therefore fits as "other specified dorsopathies." This type of code is used when you can indicate or describe the specific diagnosis or causation of condition but there is no code that indicates that specific diagnosis directly. In opposition, when the pain or dorsopathy is determined as sciatica, you can indicate M54.31 to M54.32 for sciatic pain or M54.41 to M54.42 for lumbago with sciatic pain as there are codes that specifically indicate the diagnosis for sciatica or low back with sciatica.

Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code. This means you have a patient with a dorsopathy (back pathology or pain) but cannot clearly determine a specific diagnosis or causation and would use the code M53.9 which is for "dorsopathy unspecified," as there is no clear diagnostic conclusion.

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. This in reality takes the place when a provider has several potential diagnostic possibilities or suspicions and is wanting to use a "rule out diagnosis." For example, a patient presents with lower back pain that is severe and the provider is suspicious it may be a disc pathology. However, until a proper scan or other test can provide conclusive evidence of a disc pathology the diagnosis will initiate as lower back pain (lumbago) M54.5. Once there is confirmation of the disc pathology, then the disc codes may be utilized. Be sure to only code what you can confirm based on your history, physical examination and testing. This would mean the initial diagnosis may indeed be pain but later be amended to a specific condition once confirmed.

Sign(s)/symptom(s) and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.

As confusing as it may seem at first glance, ICD10 is simply a detailed granulated method of description that can be very specific, but not always as specific as we may assume and non-specific codes that are "unspecified or other" may be appropriate and the most correct code.

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