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Internal Medicine Coding Alert

Afraid to Report Unlisted and Category III Codes? Here Are 3 Easy Tips

Let our case study and expert advice show you what to do

Substituting Category III or unlisted-procedure codes with similar established codes could lead to denials and lost reimbursement. To help your insurer develop reasonable RVUs for unlisted-procedure and Category III codes, you should use this scenario and three expert-approved steps.

"Insurers struggle with developing RVUs [relative value units] for Category III and unlisted codes, but if you provided them with direction to a valid code and value of unit, it helps make the process easier and quicker for both sides," says **Marvel Hammer, RN, CPC, CHCO,** president of MJH Consulting in Denver.

How to Direct Insurers to Proper Payment

Case study: An established Medicare patient e-mails your internist complaining of a cough (786.2) and increased mucus production (933.1, Foreign body in pharynx and larynx; larynx). The patient has no history of bronchitis or emphysema, so the physician recommends rest and an over-the-counter medication. Also, he tells the patient to come into the office if the symptoms don't improve in a few days.

To report this online exchange, you submit Category III code 0074T (Online evaluation and management service, per encounter, provided by a physician, using the Internet or similar electronic communications network, in response to a patient's request, established patient).

Snag: Your Medicare payer doesn't typically reimburse Category III codes. But you might be able to get 0074T paid if you can convince a commercial insurer that the code is comparable to a covered CPT code's work, medical malpractice risk and practice expense RVUs.

"One of the most difficult parts of this process is presenting this information to third-party payers for reimbursement," says **Brenda Dombkowski, CPC**, a compliance auditor for Yale University's Department of Internal Medicine in New Haven, Conn. "Before billing for a Category III procedure, work with physicians and the products representatives to develop an informational packet with a cost matrix. Contact your third-party medical directors and/or insurance representatives with this information for their review. Not contacting your payers prior to performing a Category III can lead to poor reimbursement and denials."

For example, after your research, you recommend that the carrier reimburse 0074T at the same rate as 99212 (Office or other outpatient visit for the evaluation and management of an established patient ...), which Medicare reimburses at about $40, depending on location. In addition to the code and medical documentation, you should send a one-page cover letter to prove your case. Here are three crucial elements you need to make the letter effective:

1. Use current codes and RVUs. When selecting a code to compare with the Category III code, be sure your internist selects one that has not been deleted. You your internist selects one that has not been deleted. You don't run much risk of this with E/M codes, but you should still ensure that you are basing your payment recommendation on the current year's RVUs so you'll get the money you deserve.

Watch out: Sometimes private-payer contracts specify that the carrier pays codes at an earlier year's rate, so you should develop your payment recommendation using that year. For instance, if the private insurer pays at 2004 rates, you should find RVUs relatively close to that year, Hammer says.

2. Don't create a grand fee for the code. Your internist should choose Category I codes that are truly reasonable and provide the insurer with a basis to follow your payment recommendation, Hammer says.

Example: You should not submit a letter to the carrier asking it to pay the same for 0074T as it does for a level-five E/M, such as 99215, when the internist simply addressed a cough and mucous build-up, coding experts say.

3. Provide your internist's reasoning. In layman's terms, your physician should describe why he provided the online E/M service and how it compares with the service 99212 represents, Hammer says. For example, the physician can point out that both 0074T and 99212 describe established patient E/M services. Also, the physician should explain that billing 99212 instead of 0074T would not be appropriate because he provided the E/M over the Internet, not in the office.

Remember: Your internist should provide a layman's description of the service, because registered nurses, adjustors and claims processors without medical backgrounds will be reading the letter, Hammer says.

Don't Give Up on Unlisted-Procedure Codes

To set a reasonable payment rate for unlisted- procedure codes, you can use the same steps as outlined above.

For example: One of your internist's Medicare patients, who is a lifetime smoker, has a cough (786.2), increased mucous production (933.1), and shortness of breath (786.05). To test for bronchitis and/or emphysema, the physician has the nurse perform maximum inspiratory (MIP) and expiratory (MEP) pressure tests. CPT offers no codes to represent these tests, so you must report 94799 (Unlisted pulmonary service or procedure).

In this case, you could compare the work involved for basic spirometry (94010, Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement[s], with or without maximal voluntary ventilation) with that of the MIP and MEP tests.