

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 3 Field-Tested Tips Improve Your "Unlisted-Procedure" Claims

Receiving fair reimbursement requires adequate preparation and documentation

If you've ever filed a claim using an unlisted-procedure code, you know how much effort is involved. To ensure that payers properly reward the physician's effort (and the coder's work in preparing the claim), our experts offer you three tips.

Tip 1: Describe the Procedure in Plain English

Anytime you file a claim using an unlisted-procedure code (for example, 37799, Unlisted procedure, vascular surgery; or 43999, Unlisted procedure, stomach), you must submit a full operative report to describe the procedure or service.

Take note: If you're looking for fair reimbursement, however, the operative notes alone won't be enough. You've got to include a separate report that explains in simple, straightforward language exactly what the physician did.

Insurers consider claims for unlisted-procedure codes on a case-by-case basis, and they determine payment based on the documentation you provide, says **Eric Sandham, CHC, CPC**, compliance manager for **Central California Faculty Medical Group**, a group practice and training facility associated with the University of California at San Francisco in Fresno. "Unfortunately, claims reviewers, especially at lower levels, do not have a high level of medical knowledge, and physicians don't always dictate the most accessible notes," he says. Part of the coder's job in preparing the claim is to act as an intermediary between the physician and the claims reviewer, providing a description of the procedure in layman's terms.

"If the person making the payment decision can't understand what the physician did, there's not much chance that the reimbursement you receive will properly reflect the effort involved," says **Marvel J. Hammer, RN, CPC, CHCO**, owner of **MJH Consulting**, a healthcare reimbursement consulting firm in Denver.

Keep it simple: Whenever possible, avoid or explain medical jargon and difficult terminology. If appropriate, you may even include diagrams or photographs to help the insurer understand the procedure you are describing with the unlisted-procedure code. "You should try to keep the description short and simple," Hammer says.

Real-world example #1: CPT includes no specific code to describe laparoscopic roux-en-y gastric bypass, so the best code to describe this procedure is 43659 (Unlisted laparoscopy procedure, stomach). When describing this procedure, you should use the surgeon's operative notes as a guide, stressing the main points of the operation and why it was necessary. A sample narrative sent to the payer might read:

"Patient suffers from extreme obesity (278.01, Morbid obesity), unresponsive to behavior modification (diet, exercise, etc...).

During surgery, the surgeon divides the stomach into upper and lower sections using a cutting surgical stapler. The upper portion of the stomach forms a small pouch. The surgeon bypasses the lower (distal) part of the stomach and the first portion of the small intestine (duodenum and jejunum). The surgeon cuts the small intestine at this point.

The surgeon then connects the lower part of the small intestine to the small stomach pouch (food will pass through a small [12 mm, or about "] opening [stoma] from the small pouch into the small intestine). The surgeon reconnects the end of the bypassed section of small intestine coming from the bypassed stomach to the lower (distal) small intestine (thereby forming a "Y"). This allows digestive juices to empty into the portion of small intestine where food is present."

Tip 2: Compare the Procedure to an Existing Code

If you want to gain appropriate payment for an unlisted-procedure claim, you should provide the insurer with an appropriate place to begin. Often, insurers pay for an unlisted-procedure claim by reading your procedure description and comparing it to a similar, listed procedure with an established reimbursement value, says **Heather Corcoran**, coding manager at **CGH Billing Services**, a medical billing firm in Louisville, Ky.

For example, if the surgeon performs an unlisted endoscopic procedure, the insurer may compare it to an equivalent open procedure with a CPT code. Generally, the insurer will judge the endoscopic procedure less invasive and less difficult than the open procedure and will accordingly pay less for the former. Nevertheless, the comparison gives the insurer a baseline from which to determine a payment value.

Take charge of your claim: Rather than allow the insurer to determine which is the "next closest" code, you should explicitly reference the nearest equivalent listed procedure in your explanatory note. "If you let the insurer choose the 'comparison' code for you, you could end up having to fight it later. For instance, the payer might compare your claim to something valued much lower than the unlisted procedure that you performed," Corcoran says.

Provide specific details: You should also specifically note how the unlisted procedure differs from the next-closest listed procedure, Sandham says. For example, was the claimed unlisted procedure more or less difficult than the "comparison" procedure? Did it take longer to complete? Was there a greater risk of complication? Will the patient require a longer recovery and more post-operative attention? Did it require special training, skill or equipment? Any of these factors can make a difference in the level of reimbursement you may expect.

Real-world example #2: CPT does not include a code to describe laparoscopic ventral hernia repair, so you should report it using 49659 (Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy). But CPT does include codes to describe laparoscopic repair of inguinal hernia (49650, Laparoscopy, surgical; repair initial inguinal hernia), as well as open repair of ventral hernia (49560, Repair initial incision or ventral hernia; reducible), and you may use these codes as a basis of comparison for 49659 in this case. For instance, you might alert the payer: "Surgeon performed laparoscopic repair of ventral hernia. This procedure is similar to, but less invasive than, open repair 49560, with postoperative care and recovery similar to that required by laparoscopic repair of inguinal hernia 49650."

Tip 3: Enlist Outside Help

If the physician uses equipment and techniques that do not have CPT codes, go to the manufacturer for reimbursement assistance. Medical technologies often evolve faster than CPT, and the manufacturers of new drugs and equipment have a vested interest in making sure carriers pay for use of the latest innovations, even if a CPT code doesn't exist to describe them.

Manufacturers often maintain free information and help lines to advise physician practices on how to approach insurers regarding new technologies, Sandham says. Use caution when applying manufacturers' suggestions, however.

Remember: You are responsible for the accuracy of your claims, and you should never misrepresent a claim to gain payment. Stick to unlisted-procedure codes when no other code(s) describe the procedure the physician performed and always provide ample documentation to justify the claim's necessity.

Helpful hint: You can find a list of unlisted-procedure codes in the "Surgery Guidelines" portion of CPT.