Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Steps Unlock Ethical Unlisted Procedure Coding Payments

Referencing the nearest equivalent CPT code could be your key to getting paid.

When CPT forces you to turn to unlisted codes, such as when your physician performs a laparoscopic uterosacral nerve ablation (LUNA) procedure, make sure you follow these simple steps or you could up with zilch.

Step 1: Never Select a 'Close but Not Quite' Code

You should never report a code that comes close to the procedure your ob-gyn performed, but doesn't quite fit. If no precise procedure or service code exists, you should report the service "using the appropriate unlisted procedure or service code," state the CPT Instructions for Use in the CPT manual.

CPT includes unlisted-procedure codes to allow you to report procedures for which there is no specific CPT descriptor available.

Payment for such claims, however, is not automatic. Your doctor must make a careful effort to document the procedure, and the information you include with your claim can make all the difference.

Step 2: Explain the Procedure in Layman's Terms

Any time you file a claim using an unlisted-procedure code (for example, 58999, Unlisted procedure, female genital system [nonobstetrical]), you should include a cover letter stating why you are using the unlisted code, says **Rebecca Lopez, CPC,** coding specialist for Bright Health Physicians' compliance department in Whittier, Calif. This separate report should explain, in simple, straightforward language, exactly what the physician did.

Part of your job when coding and 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. You may even want to include diagrams or photographs to better help the person reviewing your claim understand the procedure.

When reporting unlisted codes, experts suggest doing everything you can to make sure you get paid what you think is appropriate. In other words, overload the payer with information and always give them a way to contact you with questions.

Why: Your payers will consider claims with unlisted-procedure codes on a case-by-case basis, and they determine payment based on the documentation you provide. Unfortunately, claims reviewers frequently do not have a high level of medical knowledge, and physicians don't always dictate the most informative notes.

If the person making the payment decision doesn't understand what the physician did, your reimbursement probably won't properly reflect the effort involved.

Supply documentation: Since most carriers will no longer accept paper claims, submit your unlisted CPT code electronically with a short description of what was done in box #19 of the CMS-1500 form or its electronic equivalent. Some carriers will then expect a faxed copy of your documentation after seven to ten days or will request documentation after receiving the electronic submission.

When submitting an unlisted-procedure claim, your documentation should include the complete operative note and an explanatory cover letter.

Step 3: Reference an Existing Code

Unlisted procedure codes do not appear in the Medicare Physician Fee Schedule, so they do not have assigned fees or global periods. Your payers will generally determine payment for unlisted-procedure claims based on the documentation you provide.

You can suggest a fee by comparing the unlisted procedure to a similar, listed procedure with an established reimbursement value. It helps put your service in perspective with something they are familiar with, experts say.

Best bet: Rather than leave it up to the insurer to determine which code is the closest to what your doctor performed, you should explicitly make reference to the nearest equivalent listed procedure, Lopez recommends. After all, the treating physician is best equipped to make this determination.

Tell the carrier how the procedure you're coding for compares to, and differs from, the assigned procedure code. Answer these questions: "Was the unlisted procedure more or less difficult than the comparison procedure? Did it take longer to complete and, if so, by how much? (Try to provide percentages whenever possible.) Was there a greater risk of complication?

Will the patient require a longer recovery and more postoperative attention? Did it require special training, skill, or equipment?" Any of these factors can make a difference in the reimbursement level you may expect.

Example: Your doctor performs a (LUNA procedure for his patient with intractable pelvic pain. You won't find a code for this procedure, and because this procedure is performed on a nerve that is contained in the abdominal cavity, you will report 49329 (Unlisted laparoscopy procedure, abdomen, peritoneum and omentum).

You should use two codes to make a comparison for this procedure: 58400 (Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; [separate procedure]) and 58410 (... with presacral sympathectomy).

Why: A presacral sympathectomy involves removing or destroying a part of the presacral nerve to alleviate pain, which is very similar to performing this on the uterosacral nerve. But in most cases, when done laparoscopically, there is no accompanying uterine suspension. Since 58410 includes both a uterine suspension and the nerve disruption, you will need to compare the LUNA to 58410, but representing less work.

To calculate how much less work, you would need to subtract the total relative value units (RVUs) for 58400 (12.01) from those for 58410 (21.78) to come up with an approximation. The resulting RVUs (9.77) can then be compared to a listed laparoscopic code. In this case, 49322 (Laparoscopy, surgical; with aspiration of cavity or cyst [e.g., ovarian cyst] [single or multiple]) with 9.82 RVUs comes the closest. At that point your physician would need to decide if the work involved was more or less than a laparoscopic aspiration and set the requested reimbursement accordingly.

Step 4: Appeal When Warranted

Even the best documentation won't always get you the reimbursement your doctor deserves for an unlisted procedure. If payment is not appropriate, you may need to appeal.

Good advice: Find out where your unlisted claim is going.

"Make sure you get the name and department, so you can follow up your request," Lopez says. If your physician uses equipment and techniques that have no dedicated CPT codes, such as the a Vinci robot for selected laparoscopic procedures, you may be able to enlist the manufacturer's aid to receive appropriate reimbursement. Manufacturers often maintain free information and help lines to advise physician practices on how to approach insurers regarding new technologies.

Sometimes manufacturers' representatives will have helpful documentation about the equipment or technique. You could use this as a second resource, but don't rely on the representatives to assist you with the coding aspect of the service, experts caution.

You can also turn to specialty societies for help with appeals and documentation.

Good practice: When your doctor repeatedly performs the same type of unlisted procedure, prepare an information file so you don't have to reinvent the wheel every time you submit a claim. Each time a carrier denies a similar claim, you will already have an appeals packet ready to send the payer to defend your claim.