Part B Insider (Multispecialty) Coding Alert

PART B REVENUE BOOSTER: 3 Tips Sharpen Your Unlisted Coding Finesse

Tip: Don't forget to compare your unlisted procedure to an existing code

You can streamline your unlisted-procedure code claims and ensure that your physician gets reimbursed without specific codes by following these three pointers.

Tip 1: Describe the Procedure in Plain English

Any time you file a claim using an unlisted-procedure code (for example, 90779 [Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion]), you should include a separate report that explains, in simple, straightforward language, exactly what the physician did.

Keep in mind: Insurers consider claims for 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.

Good idea: You may even want to include diagrams or photographs to better help the insurer understand the procedure. Some practices recommend highlighting or making notes on the actual op report indicating where in the body of the op report the provider describes the
unlisted procedure.

Tip 2: Compare the Procedure

An insurer will decide to pay an unlisted-procedure claim by comparing your procedure description to a similar, listed procedure with an established reimbursement value.

Rather than leave it up to the insurer to determine which code is the -next closest,- you should explicitly make reference to the nearest equivalent listed procedure. After all, the treating physician is best equipped to make this determination.

You also should note the specific ways that the unlisted procedure differs from the next-closest procedure listed in CPT.

Example: Suppose a cardiologist cardioverts a patient using the patient's internal defibrillator. Using a patient's internal defibrillator is somewhat of a hybrid procedure, meaning that you aren't likely to find a regular CPT code to represent it. In this case, you should show that -internal- cardioversion is a similar procedure but one in which the cardiologist passes electrodes to the inside of the patient's heart through a transvenous approach.

This will help relate the procedure performed to an existing procedure as support for reimbursement. And explain how your procedure differs to show why you didn't choose the existing code, says **Heather Corcoran**, coding manager at **CGH Billing** in Louisville, Ky. Basing your fee on a similar procedure is helpful in claims processing but not mandatory.

For the scenario above, you should request reimbursement at a level somewhere between that of 92960 (Cardioversion, elective, electrical, conversion of arrhythmia; external), 92961 (... internal [separate procedure]) and 93744 (Electronic analysis of pacing cardioverter-defibrillator).

In other words, this procedure is a hybrid between these three codes: internal conversion (because the cardiologist is delivering impulses directly to the myocardium), external cardioversion (because the cardiologist is performing the procedure noninvasively), and defibrillator interrogation (because the cardiologist is using a previously implanted cardiac rhythm management device to perform the procedure).

Tip 3: Solicit Outside Advice

If the physician uses equipment and techniques for which there is no dedicated CPT code, you may be able to enlist the manufacturer's aid to receive appropriate reimbursement, says **Randall Karpf** with **East Billing** in East Hartford, Conn.

Manufacturers often maintain free information and help lines to advise physician practices on how to approach insurers regarding new technologies. Use caution when applying manufacturers- suggestions, however, because you are responsible for the accuracy of your claims. You should never misrepresent a claim to gain payment.