Eli's Rehab Report

How to Instruct Payers About New Technology

When you submit 64999, pack 'why' and 'how' into the cover letter

When you're submitting an unlisted-procedure code to a patient's insurance carrier for a new technology that doesn't have a CPT code, you'll have to pack a lot of punch into your cover letter to get the message across. These tips will help your success rate.

The challenge: Once your claim reaches the payer, some don't understand the need for reading and understanding the information you submit. Another challenge is finding insurance provider and/or claims representatives who educate themselves about new (and proven) technology or procedure techniques and therefore understand your claim, says **Marvel J. Hammer, RN, CPC, CHCO**, president of MJH Consulting in Denver.

Tip #1: Track new procedure preferences

When a provider starts performing a "new" procedure, Hammer recommends that you verify with top payers from your provider mix whether they cover the procedure. If so, learn how each insurer wants you to report the service - with a HCPCS code, a Category III code, or an unlisted-procedure code. Create a spreadsheet of the preferences for your coders to use for correct billing.

Tip #2: Cover bases in your cover letter

An information-packed cover letter with your claim plays an important role in reimbursement:

1. Write a brief paragraph explaining why you are using the unlisted-procedure code. Hammer typically includes the quotation about using unlisted-procedure codes directly from the Instructions for Use of the CPT book found in the Introduction of the AMA CPT. (Also see the Unlisted Service or Procedure notes in guidelines for each CPT section.)

2. Include a brief paragraph explaining in layman's terms the procedure performed and why it is medically necessary for this patient. Also summarize other physical medicine and rehab procedures the patient has undergone without successful relief.

3. Include a brief paragraph explaining the basis for the fee submitted for the unlisted procedure. Common denominators include similar work, practice expense and malpractice risk compared to a "valid" CPT code. "You should use the unlisted code and then compare it to a procedure code that is 'close,' in order to select the reimbursement you should charge," says **Heather Corcoran**, manager at CGH **Billing Services** in Louisville, Ky. Basing your fee on a similar procedure is helpful in claim processing but not mandatory.

Tip #3: Report related services correctly

All unlisted-procedure codes are "stand alones," meaning you cannot append modifiers to them. Instead, take appropriate modifiers into consideration when you calculate the fee. Begin by basing your fee on a comparable procedure and adjust it according to how any modifiers might affect it (such as reducing the fee if you would normally append modifier -52 to the claim).

However, you can report 64999 (Unlisted procedure, nervous system) in conjunction with other separate, distinct services performed at the same session that do have valid CPT codes (such as 20552, Injection[s]; single or multiple trigger point[s], one or two muscle[s], or 20553, ... single or multiple trigger point[s], three or more muscles, for trigger point injections during the same visit).

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Tip #4: Lobby for new codes

The AMA encourages providers to suggest new codes for inclusion in CPT. It's a long, drawn-out process, but some physical medicine and rehab providers believe it's worth pursuing.

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