Pain Management Coding Alert

Reimbursement: Follow These 3 Tips to File Successful 'Unlisted' Claims

The better your provider's documentation, the better your chances at payment.

Submitting claims with unlisted codes such as 22899 (Unlisted procedure, spine) or 64999 (Unlisted procedure, nervous system) might grate on your nerves, but sometimes you have no other choice. Take heart in knowing that reporting "unlisted" doesn't mean all hope for decent reimbursement is lost. Follow these expert tips on explaining why an "unlisted" code was the best choice for your claim, and insurers will be more likely to pay without qualms.

Tip 1: Focus on Clear, Uncomplicated Documentation

Any time you report an unlisted procedure code, include a separate cover letter that explains exactly what the provider did in straightforward language. If you have diagrams or photographs to better illustrate the procedure, include those as well. Some groups ask physicians to highlight or make notes on the actual documentation of services to indicate any description of the procedure performed. Any notes regarding the time, effort, and equipment necessary to provide the service will boost your chances of getting the claim paid.

Example: CPT® requires you to report spinal hardware injections with 64999. Appropriate explanatory notes from your provider might read, "The patient's spinal surgeon has requested these diagnostic injections to determine whether the implanted metal hardware is the source of the patient's persistent postoperative back pain. Spinal hardware blocks are performed by injecting a small amount of local anesthetic alongside each of the pedicle spinal screws that were placed in each vertebrae during the patient's previous spinal fusion surgery. If the patient's pain is temporarily relieved by the injection(s), it may indicate that the spinal hardware is contributing as a source of the patient's continuing pain. These diagnostic injections are used to determine whether which, if any, of the spinal pedicle screws should be surgically removed."

Tip 2: Explain Why You Opted for 'Unlisted'

Include information in the claim's cover letter explaining why the provider is using the unlisted code.

"Remember that unless the physician performs the work described in an existing CPT® code, you are obligated to use an unlisted code to describe the physician work," says **Gregory Przybylski, MD,** director of neurosurgery at New Jersey Neuroscience Institute, JFK Medical Center, in Edison.

Clear explanation: The note explaining why you chose an unlisted code might read, "Based on the Instructions for Use of CPT® Codebook. 'Do not select a CPT® code that merely approximates the service provided. If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code.' I have found that currently no CPT® code exists for spinal hardware injections, consequently I am compliantly submitting 64999 - Unlisted procedure, nervous system for my services provided to your insured. In addition, both the April 2011 and May 2012 issues of the AMA CPT® Assistant publication direct providers to report this code for spinal hardware injections."

The provider would substitute the appropriate unlisted code and descriptor, as well as any published reference regarding compliant coding for the various unlisted procedures.

Example 1: For instance, an explanation for dry needling might include, "...consequently, I am compliantly submitting 20999 (Unlisted procedure, musculoskeletal system, general) for my services provided to your insured. In addition, the September 2003 issue of the AMA CPT® Assistant publication, directed providers to report this code for dry needling."

Example 2: CPT® 2015 introduced several new codes for vertebral augmentation/kyphoplasty (22513-22515, Percutaneous vertebral augmentation, including cavity creation [fracture reduction and bone biopsy included when

performed] using mechanical device [e.g., kyphoplasty], 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance ...). These new choices do not include a code specific to the cervical region. If your provider performs a cervical kyphoplasty procedure, you should submit 22899 with documentation explaining the procedure and why you needed to report the work with an unlisted code.

Example 3: At this time, there is no specific CPT® code that accurately describes radiofrequency gangliolysis (RFG) of the sphenopalatine ganglion. Your code choices do include 64505 (Injection, anesthetic agent; sphenopalatine ganglion), but this code describes the injection into the sphenopalatine ganglion rather than RFG. Because of this, you should file with 64999.

Tip 3: Include a Reasonable Comparison

Insurers consider unlisted procedure claims on a case-by-case basis. Any payment you receive will be based on comparing your procedure description to a similar, valid CPT® procedure code with an established reimbursement value. This comparison code should be similar in physician work, malpractice risk, and practice expense when compared to the unlisted procedure.

"You should consider comparison codes that use a similar approach (such as anterior versus posterior, open versus percutaneous), as well as a similar spinal region (cervical, thoracic or lumbar) when such a comparison code is available," says Przybylski.

Referring to an existing code on your claim can help your insurer determine an adequate payment. If possible, look for a CPT® code for the nearest similar procedure. Also, describe how the procedure that your surgeon does differs from the next-closest listed procedure.

Tip: Don't let the insurer determine which CPT® code is the "next closest" for your physician's service.

Example 1: Your physician administers an injection for ganglion impar block, which CPT® directs you to report with 64999. For comparison purposes for code valuation, some physicians compare the injection of local anesthetic to 64450 (Injection, anesthetic agent; other peripheral nerve or branch), which has a national unadjusted RVU of 2.28 for a non-facility place of service. If he performed nerve destruction instead of administering a temporary numbing agent, you could compare the destructive procedure to 64640 (Destruction by neurolytic agent; other peripheral nerve or branch), with a non-facility national unadjusted RVU of 3.79.

Example 2: Pulsed radiofrequency of a peripheral nerve is reported with 64999. Again, a good comparison for RVU valuation is 64640.

Coming next month: Three more tips for helping your "unlisted" claims find payer success.