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Eli's Rehab Report

Latch Onto These 3 Steps for Using Unlisted-Procedure Codes

A code that's 'close' doesn't mean it's the right choice

Are you ready to throw your hands up when it comes to reporting physical medicine and rehab procedures that don't have specific codes? Reporting an unlisted-procedure code doesn't always mean you'll be staring at a denial. In fact, using them correctly could boost your bottom line - as long as you follow these three expert tips.

Step 1: Ask, 'Does This Procedure Have a Code?'

CPT lacks specific codes for many common physical medicine and rehab procedures, including:

1. Spinal hardware injections
2. Pars intra-articularis injections
3. Chemodenervation (such as botulinum type A injections into the esophagus)
4. IV sympathetic nerve blocks
5. Ganglion impar injections
6. Pulsed radiofrequency of any nerve
7. Destruction of dorsal root ganglion, lumbar sympathetic nerves, SI (sacroiliac) joint nerves

When you don't have a specific code, you typically report **CPT 64999** (Unlisted procedure, nervous system). But you have other options. Other codes with potential physical medicine and rehab use include 22899 (Unlisted procedure, spine), 95999 (Unlisted neurological or neuromuscular diagnostic procedure) and 97799 (Unlisted physical medicine/rehabilitation service or procedure), says **Marvel J. Hammer, RN, CPC, CHCO**, president of MJH Consulting in Denver.

Note: One procedure that recently dropped off the unlisted-procedure-code list is central motor evoked potential studies. CPT 2005 introduced 95928 (Central motor evoked potential study [transcranial motor stimulation]; upper limbs) and 95929 (... lower limbs) in place of an unlisted-procedure code.

Another example is the change for intradiskal electrothermal annuloplasty (IDEA). Medicare released 0062T (Percutaneous intradiskal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; single level) and +0063T (... one or more additional levels [list separately in addition to 0062T for primary procedure]) July 1, 2004, to ease the frequent use of 64999 for this procedure.

Step 2: Avoid Using 'Close' Procedures

Many coders try to avoid reporting "unlisted-procedure" codes such as 64999 because they don't adequately describe the procedure in question. Because of this, some coders report codes that were close to the procedure performed instead of the appropriate section's unlisted-procedure code.

You should never use a code that's close to a different procedure in place of an unlisted-procedure code. "That is called

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'incorrect coding' and is absolutely not acceptable," says **Heather Corcoran**, manager at CGH Billing Services in Louisville, Ky.

Fraud alert: The primary reason this is inappropriate is potential fraud. "Selecting a code that is 'close' is not compliant coding," Hammer says. "Knowingly and willingly coding a service or procedure with a code for the explicit motivation of bypassing denials and ensuring payment is fraud. The documentation will not support the procedure being billed."

If you're not reporting an unlisted-procedure code, you could also be impeding a process that creates new codes for use in the future. "At some point, [the American Medical Association] may create a Category III code for further tracking. If the coder continually picks codes that are close to the real procedure instead of using the unlisted code, she is being noncompliant and is being improperly reimbursed. She also is impeding the natural progression of code development for the CPT manual," says **Gina Graham, CPC**, a pain management coder in Hepzibah, Ga.

Checkpoint: In some instances, Graham says, it might be appropriate to add modifier -22 (Unusual procedural services) to indicate increased difficulty during the procedure (such as when the physician administers transforaminal injections through a different route into the spine). Coders may opt for this (or add modifier -52, Reduced services, instead when the practitioner performs a portion of a procedure) in geographical regions such as New York where carriers do not reimburse for unlisted-procedure codes.

In addition to these noncompliance viewpoints, CPT includes instructions that you should not select a CPT code that merely approximates the service provided. If no such procedure or service exists, CPT directs you to report the service using the appropriate unlisted-procedure or -service code. The implication is that it's no longer acceptable to choose a code that is "close" to what was performed, Hammer says.

After all, you wouldn't have the unlisted-procedure codes as an option if the AMA preferred that you pick something close, Corcoran says.

Step 3: Recognize the Roadblocks

Many of the challenges associated with reporting 64999 for so many physical medicine and rehab procedures fall into two categories: CPT-related and payer-related.

"CPT bases unlisted-procedure codes on anatomic site in most instances, so one unlisted code for the nervous system is somewhat problematic," Hammer says.

Graham agrees. "The neurological system is such a complex one that you could only hope the AMA would create an unlisted code for procedures for the brain, the spine, and the peripheral nervous system," she says. "Other CPT chapters include numerous unlisted codes. Having only one unlisted code for the entire neurological section is not adequate for coding all unlisted ... procedures."

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