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Pain Management Coding Alert

Documentation: Watch Your Units and Modifiers for 'Unlisted Procedure' Claims

The more information you can include, the better.

You never want to file a claim with an "unlisted" procedure code, but sometimes you can't avoid it. The good news is, you can boost your chances of success by including certain details in the documentation. Read on for three ways to improve any claims you submit with 22899 (Unlisted procedure, spine) or 64999 (Unlisted procedure, nervous system).

Stick to a Single Unit

Because the unlisted codes don't have valuations, you should always bill with a maximum of one unit of service.

"While many procedures may involve a series of codes, known as component coding, the unlisted code is meant to encompass all of the additional procedures for which there is no CPT® code available to report," explains **Gregory Przybylski, MD**, director of neurosurgery at New Jersey Neuroscience Institute, JFK Medical Center, in Edison.

Support: According to the April 2001 CPT® Assistant, "... When performing two or more procedures that require the use of the **same** unlisted code, the unlisted code used should only be reported **once** to identify the services provided. This is due to the fact that the unlisted code does not identify a specific unit value or service. Unit values are not assigned to unlisted codes since the codes do not identify usual procedural components or the effort/skill required for the service..."

Include Every Bit of Information

If your provider uses equipment and/or techniques for which there is no dedicated CPT® code, you may be able to enlist the manufacturer's aid to receive appropriate reimbursement.

Here's why: Manufacturers often maintain free information, resources and help lines to advise physicians on how to approach insurers regarding new technologies.

"Use caution when applying manufacturer suggestions, however, because you are responsible for the accuracy of your claims," Przybylski warns. "You should never misrepresent a claim to gain a payment. Ultimately, the AMA in cooperation with the professional medical associations determines the rules for appropriate use of CPT®."

Insurer clearance: Some private or third-party payers might not want to handle claims with unlisted codes. If you aren't sure whether the payer will accept a claim, talk with your representative and get any clearance in writing. Include a copy of their approval when you submit the claim.

"If pre-authorization is necessary, it's best to establish coverage for the specific unlisted code at that point," suggests **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO**, of MJH Consulting in Denver, Co. "It's also helpful to have the comparative code available for reference at pre-authorization."

Bonus: Medical specialty societies might also be able to offer guidance or supporting information about the procedure your physician performed.

Skip the Modifiers

Modifiers are used to indicate that the service your provider performed was altered a bit from the specific CPT® code descriptor, but not changed from the basic service. They can also be used to provide payers with additional details about the service but that doesn't work with "unlisted" claims.

"While proper use of modifiers for existing CPT® codes is critical in many circumstances to receive proper payment, they are not intended to be applied to unlisted codes," says Przybylski.

Avoid: Do not append modifiers to unlisted procedure codes, however, because the unlisted codes do not describe specific procedures.

Editor's note: For more on bolstering your "unlisted" claims with clear, uncomplicated documentation, explanations of why you opted for an "unlisted" code, and reimbursement comparisons, see "Start Your 'Unlisted' Claims on the Right Path With These 3 Tips" in Neurology and Pain Management Coding Alert, Vol. 17, N. 5.