

# Unlisted procedures: Strategies for successful reimbursement



by Kenneth Simon, MD, FACS; Samuel Smith, MD, FACS;  
Teri Romano, RN, MBA, CPC, CMDP; and Jan Nagle, MS, RPh

**W**hen seeking reimbursement for a surgical procedure, it is important to select the Current Procedural Terminology (CPT)\* code or Healthcare Common Procedure Coding System (HCPCS) Level II code that accurately and precisely describes the services provided. If no specific CPT or HCPCS code exists, then the procedure must be reported using an appropriate “unlisted” CPT code. Some coding staff and surgeons are under the misconception that unlisted codes equate to unpaid codes. However, unlisted CPT codes, when reported with appropriate documentation, should be reimbursed. It is the responsibility of the surgeon and the coding or billing staff to report unlisted CPT codes appropriately and follow up with payors if a claim is denied. This column provides information about reporting an unlisted CPT code.

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## Unlisted CPT code reporting requirements

An unlisted code should be reported using the standard CMS-1500 form. Today, Medicare and most payors require that the CMS-1500 form be submitted electronically to facilitate expedient claim submission and, in a best-case scenario, expedient reimbursement.

Reporting an unlisted procedure typically requires more steps before and after the procedure than reporting a procedure that has a specific CPT or HCPCS code. To lessen the chance of payment denial for elective cases, it is best to obtain prior authorization in writing from the payor before performing an unlisted procedure. Most payors have a prior authorization form that allows the surgeon to describe the planned procedure and the medical necessity of the operation.

In those instances where an unlisted procedure is performed without prior authorization (for example, an urgent operation or unanticipated

## CODING TIP

Medicare does not assign a value to CPT Category III codes. Hence, they should be reported the same way that unlisted codes are reported.

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ACS Surgical Coding Workshops provide opportunities for surgeons and/or their coding staff to learn how to accurately report medical procedures and services. For more information or to sign up for one of the 2017 ACS Surgical Coding Workshops, visit [facs.org/advocacy/practmanagement/workshops](http://facs.org/advocacy/practmanagement/workshops).

72| intraoperative procedure), a copy of the operative report should be submitted, along with supporting information outlining the decision-making process and the medical rationale for performing the operation. For Medicare patients, this documentation should be submitted to the appropriate Medicare Administrative Contractor (MAC). Individual payors may have processes in place for submitting claims for unlisted codes. It is important to be familiar with your top payors' specific process to help expedite the claim.

When submitting an unlisted procedure, a concise description of the procedure must be included in Item 19 of the CMS-1500 paper form or the electronic media claim (EMC) form.

This concise statement must be 80 characters or less. Even if the description can be summarized in this small space, it is best to send additional claim attachments. Common attachments include a cover letter, Certificate of Medical Necessity, discharge

summary, and/or operative report. These attachments are sent with the original claim, either electronically or by fax, e-mail, or hard copy based on the payor's rules. After the claim has been submitted, it is important to review the Explanation of Benefit for appropriate reimbursement.

#### Fee-setting considerations for unlisted CPT codes

Your charge for the unlisted procedure is included in Item 24.F of the claim form.

To support your charge, it is recommended that you attach a cover letter. You should adhere to the following steps in writing the cover letter:

- Choose a comparison code that is similar to the unlisted procedure performed. This code should represent surgery on the same body area. For example, you may choose the CPT code for open partial gastrectomy as your comparison code for a partial gastrectomy conducted using a laparoscopic approach. Each organ system and/or body area section of the CPT

manual has an unlisted code that corresponds to an unlisted procedure in that organ system and/or body area.

- List two or three factors that make the unlisted procedure the same work, or more or less difficult than the comparison code. For example, your letter could indicate that the unlisted procedure required a different operative approach and approximately 30 minutes of additional operative time than the comparison CPT code.
- Indicate the difference in work between the unlisted procedure and the comparison code using a percentage. For example, you may estimate that the unlisted procedure required 50 percent more time for exposure, exploration, and closure than the comparison CPT code.
- Indicate the normal fee for the comparison CPT code and indicate the fee for the unlisted CPT code based on the percentage of more or less work required and documented in your letter. For example, you may indicate that your normal

TABLE 1. EXAMPLES OF CPT UNLISTED CODES AND COMPARISON CPT CODES

Procedure performed	Unlisted CPT code reported on claim form	Comparison CPT code referenced in cover letter
Laparoscopic subtotal gastrectomy with Roux-en-Y	43659, <i>Unlisted laparoscopy procedure, stomach</i>	43633, <i>Gastrectomy, partial, distal; with Roux-en-Y reconstruction</i>
Laparoscopic gastrojejunostomy	43659, <i>Unlisted laparoscopy procedure, stomach</i>	43820, <i>Gastrojejunostomy; without vagotomy</i>
Laparoscopic internal hernia repair	44238, <i>Unlisted laparoscopy procedure, intestine (except rectum)</i>	44050, <i>Reduction volvulus, intussusception, internal hernia by laparotomy</i>
Laparoscopic pylorotomy	43659, <i>Unlisted laparoscopy procedure, stomach</i>	43800, <i>Pyloroplasty</i>
Open appendicostomy	44799, <i>Unlisted procedure, small intestine</i>	44300, <i>Placement, enterostomy or cecostomy, tube open (eg, for feeding or decompression) (separate procedure)</i>
Phlebectomy, less than 10 stabs	37799, <i>Unlisted procedure, vascular surgery</i>	37765, <i>Stab phlebectomy of varicose veins, 1 extremity, 10-20 stab incisions</i>
Hemorrhoidectomy, external, single column/group	46999, <i>Unlisted procedure, anus</i>	46255, <i>Hemorrhoidectomy, internal and external, single column/group</i>

fee for comparison CPT code is \$1,000, and therefore you have set your fee for the unlisted procedure at \$1,500 because it required 50 percent more time for exposure and exploration.

- For Medicare patients, if the unlisted procedure performed is one that other surgeons may perform in similar clinical circumstances, it would be helpful to share this information with the surgical representative on the Medicare Contractor Advisory Committee (CAC). This exchange provides the opportunity to inform and educate the Medicare Contractor Medical Director (CMD) of the new procedure so that future cases may be reviewed and

†Centers for Medicare & Medicaid Services. *Medicare Claims Processing Manual*, Chapter 26: Completing and Processing Form CMS-1500 Data Set (Rev. 3637, 10-28-16). Available at: [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf). Accessed June 30, 2017.

processed more efficiently. Eliciting the support of the surgery CAC representative provides the opportunity to establish open lines of communication with the CMD to discuss coding and billing issues as they arise, including changes and updates in payment, and other pertinent information between the contractor and medical community.

Keep in mind that the percentage indicated in step 3 is critically important, although the payor will adjust up or down from its fee schedule, not the physician's charge.

**Coding examples**

Table 1 on this page provides examples of CPT unlisted codes and comparison CPT codes that should be reported for procedures that do not have a specific CPT or HCPCS code.

**Conclusion**

When reporting an unlisted code to describe a procedure or service, it is necessary to submit supporting documentation along with the claim to provide an adequate description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. For more detailed information about submitting an unlisted code to Medicare, see Chapter 26 of the Medicare Claims Processing Manual.† ♦