PATIENT ADVOCACY CORNER – UNLISTED CODES

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"How do I code a procedure for which there is no existing CPT Code?"

This is a perplexing problem facing our members every time an operative procedure is performed for which no CPT code exists. With the advent of the endoscope, many traditionally open procedures are now being performed endoscopically rather than via the open approach. Examples of this include endoscopic sphenopalatine artery ligation, endoscopic skull base surgery, and endoscopic medial maxillectomy to name but a few.

Let us use the example of endoscopic transnasal sphenopalatine artery ligation and examine the following options:

31238-22 Nasal/Sinus Endoscopy, Surgical; with control of nasal hemorrhage (RVU=5.63; 0 Day Global Period): To paraphrase the vignette for 31238: The patient has epistaxis which has not been controlled with nasal packing and will usually have a bleeding source in the posterior nasal cavity from the posterior ethmoid artery or a branch of the sphenopalatine artery. Quoting from CPT 2006, "Modifier 22 Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate."

30920-52 Ligation arteries; internal maxillary artery, transantral (RVU=19.62; 90 Day Global Period): CPT 2006 states the following for modifier 52- Reduced Services: "Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service…."

30999 Unlisted procedure, nose or 31299 Unlisted procedure, accessory sinuses: Unlisted codes do not have defined global periods but it is reasonable to assume a 0-day global which is consistent with existing codes in the family. However, this is ultimately a payer policy determination and may vary from payer to payer.

Each one of these options has advantages and disadvantages:
31238-with modifier 22: This is a reasonable and accurate coding option, however payer reimbursement may be lower than what surgeons feel is consistent with the associated physician work.

30920-with modifier 52: To use this option, the service reported should be fundamentally the same as the base code but "partially reduced or eliminated" as defined above. Professional coders would argue this is not the case in this scenario, and that it violates basic CPT coding principles. Furthermore, the AMA does not encourage the use of an open procedure code when an endoscopic procedure is being performed. Some members of the ARS view this differently and are of the opinion that operating transnasal and endoscopically on the sphenopalatine artery is conceptually similar to transantral and microscopic ligation of the internal maxillary artery.

30999 or 31299-Unlisted Code: This is the option most professional coders would recommend but is most controversial among our members for the following reasons:
1. Members claim they don't get paid.
2. Paper work and documentation may be considered burdensome.
3. Members are uncertain about what charge to attach to the unlisted code. One should choose a relatively close existing code and give justification for its use as the charge benchmark.

All of the options presented above require the following:
1) Claims should be submitted via paper and need an accompanying detailed operative note.
2) The claim will be subjected to medical review and may be delayed weeks in processing. It is recommended that a cover letter accompany these submissions to explain in lay language what service(s) were performed and the justification for the charge submitted. One should create a standard letter and then customize it on a per patient basis.

What about long-term fixes? If CPT code 31238 evolves clinically to describe transnasal endoscopic sphenopalatine artery ligation, it could be editorially changed through the CPT Editorial Panel process and/or revalued through the AMA's Relative Value Update Committee (RUC) process to reflect the change. Requesting a new category I CPT code is not an appealing option at this time. Pursuing a new category I CPT code is a time consuming and costly process. Pursing a category III CPT code (new technology code) is a possibility, however, many members state that they encounter similar reimbursement challenges with a category III code as with an unlisted code.

Ultimately, it is the surgeon who is responsible for the codes submitted. Correct coding is important for many reasons, not the least of which is the potential for audit. Our healthcare system is highly dependent on the appropriate distribution and use of resources through CPT coding. The use of the unlisted CPT code helps with the CPT development process and especially with the relative value unit allocation when a new procedure is proposed for its own code. We recommend asking your individual carriers how they want such a service

reported. In addition, the ARS Patient Advocacy Committee and the AAO-HNS Center for Practice Services are available to members for coding and reimbursement advice.