Unlisted Procedure Codes Category III CPT Codes

Frequently Asked Questions

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The Current Procedural Terminology (CPT®) Manual requires that clinicians "[s]elect the name of the procedure or service that accurately identifies the service performed. 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." Use of an unlisted code is common when a physician performs a new procedure or utilizes new technology when no other CPT code adequately describes the procedure or service. While there may be some resistance to using an unlisted code, in many cases it is the most appropriate code to use.

Category III CPT codes are for emerging technologies, services, and procedures. They enable physicians and outpatient facilities to report accurately and gather data on clinical efficacy, utilization, and outcomes. According to the American Medical Association, a Category III CPT code must be used in place of an unlisted code if the Category III code accurately identifies the service performed.

Below are some FAQs, and a few guidelines to assist with the use of Category III CPT and unlisted codes.

What is an Unlisted Code?

Unlike other CPT codes, unlisted codes do not describe a specific procedure or service. Some examples of unlisted codes used in orthopedics are:

- 27599 Unlisted procedure, femur or knee
- 29999 Unlisted procedure, arthroscopy
- 27899 Unlisted procedure, leg or ankle

Relative value units (RVUs) are not assigned to either Category III or unlisted CPT codes because the codes do not identify the effort/skill required to provide the service and are not valued by the RVS Update Committee (RUC). While Category III CPT codes identify the usual procedural components, it is necessary to provide specific information regarding the procedure(s) and/or services performed (i.e., operative note, office notes) when using an unlisted code. The supporting documentation should include an adequate definition or description of the nature, extent and need for the procedure or service, as well as the time, effort, and equipment necessary to provide the service.

Source: CPT Assistant December 2012 and CPT Assistant November 2010

Can I choose a code that is close to the description?

It is always important that the CPT code reported accurately describe the service that was performed. It is equally important that a code that is "close to" the procedure performed not be selected in lieu of an unlisted code. While the use of an unlisted procedure code requires a special report or documentation to describe the service, correct coding demands that the code reported is appropriate for the service provided (i.e., a code that most accurately represents the service provided), and not a code that is similar but actually represents another service.

Source: CPT Assistant December 2010

Can I use multiple unlisted codes?

When performing two or more procedures that require the use of the same unlisted code, the unlisted code should be reported only once to identify the services provided (same anatomic locations). This is due to the fact that the unlisted code does not identify a specific unit value or service. If two or more procedures that require the use of an unlisted code are performed on different anatomic locations the unlisted code may be reported for each different anatomic location.

Source: CPT Assistant November 2010 and CPT Assistant April 2012

Can I use modifiers with unlisted codes?

It is not appropriate to append any modifier to an unlisted code because modifiers are used to indicate that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code. Unlisted codes do not describe a specific service; therefore, it is not necessary to utilize modifiers.

Source: CPT Assistant August 2002

How do I prior authorize a Category III or unlisted code?

The prior authorization process does not change when using either a Category III or an unlisted code. Prior authorization will require a little more documentation to support the code being reported. During the process the physician will need to provide a detailed description of the procedure. This will help the payer understand what is being requested. If the request is denied, the physician should send an appeal letter along with clinical notes justifying the medical necessity for the procedure. It may also be helpful to provide a comparable procedure code and description. As a reminder, original Medicare does not allow for prior authorization.

How is payment determined for these codes?

The most common way payers determine payment is by comparison to a similar procedure (similar to how realtors run a comparable report to determine the sales price of a home). The comparative procedure should have a similar approach and similar anatomical site. It is instrumental to provide the RVUs and/or charges for the similar procedure and provide an explanation of how the current procedure is more or less difficult from the comparable procedure. For example, provide a cover letter that outlines the difference in the amount of time, work, technical expertise and use of equipment necessary to perform the procedures. Payers are often assisted in processing a claim for an unlisted or Category III CPT code procedure by providing this comparison.

Whenever reporting a service using one of these codes, use the freeform field of the claim form (61 characters in length) to present a crosswalk to another procedure believed to be fairly equivalent, or to offer a comparison to a code for which there is an existing valuation. For example, "XXX99 (unlisted code) comparable to XXXXX, payment of $XXX. XX expected." It is important to recognize that payers will commonly make the payment decision based on their fee schedule and not necessarily the submitted charge.

What do I need to do when billing with an unlisted code?

The first step is to always contact the payer for appropriate billing instructions. The office will need to determine if the payer allows electronic submission or if a paper claim is required. Next the physician will need to

determine an appropriate comparable procedure. The payer will want to know the differences between the two procedures and whether the current procedure requires more or less work, time, expertise, etc. The provider will also need to determine a fee to charge for the procedure.

Suggested Steps for Billing an Unlisted or Category III CPT Code

Contact the payer for appropriate billing instructions (especially determine whether electronic submission is acceptable or if paper submission is required), and request a copy of all instructions in writing. Information may also be available on the payer's website.

Obtain prior authorization for any additional services you intend to report with the unlisted code (excluding original Medicare) and follow their guidance.

Determine an appropriate comparable procedure and identify differences between it and the new procedure you have performed. Include these differences in your cover letter.

Gather RVUs, charges and/or payment for the similar procedure. Most payers are likely to make the payment determination based on their fee schedule for the comparable procedure.

Be prepared to submit supporting documentation, which may include:

- Clinic notes to support medical necessity of the procedure
- Operative note providing the nature and extent of the patient condition and detailing the work involved in the procedure
- Published articles and clinical information supporting the efficacy of the procedure
- Cover letter that is concise and outlines the procedure, medical necessity, and fee with supporting justification. See the sample letter that follows.

Clearly document the work performed and medical necessity for the procedure.

Prepare for payment delays. In most instances, payers will perform a more detailed review of your claim when an unlisted code is submitted. Plan to appeal the payer's decision if it is not in your favor.

Pitfalls to Avoid

- Do not report a code that is "close to" but describes a different procedure in lieu of an unlisted code.
- Do not use modifiers with unlisted codes.
- Do not report multiple unlisted codes on the same claim (in most instances).
- Do not provide vague or nonspecific documentation.
- Do not choose a comparable procedure that does not reflect a similar approach or technique.
- Do not use an unlisted code to unbundle procedures that are included in the global surgery.

Category III CPT Billing and Reimbursement (0232T, 0481T, 0558T, 0559T, 0560T, 0561T, 0562T, 0707T)

As stated previously, Category III codes are for emerging technologies, services, and procedures. It is important to note, though, that the approval of the Category III CPT code does not:

- Guarantee coverage by third party health payers.
- Set a national or local payment level for physician services.

In fact, payers may not immediately update their claims processing systems to include new Category III codes. Payers that have implemented the new Category III code may request documentation of clinical efficacy to support coverage. Reporting Category III codes can also initiate a dialogue between the payer and the physician on the payment level.

The physician may want to offer a crosswalk analysis in communicating with a payer about a new code. The crosswalk first identifies a reference procedure with an established payment level. Next, the physician may suggest that payment for the new Category III code should be at the same rate as the reference procedure rate because both procedures require similar physician time, effort, and complexity, or suggest a slight positive or negative adjustment based on differences to the reference procedure. The payer may accept the "comparability" of the procedures and crosswalk payment from the reference procedure to the new Category III code.

For further assistance with reimbursement questions, contact the Zimmer Biomet Reimbursement Hotline at 866-946-0444 or reimbursement@zimmerbiomet.com, or visit our reimbursement web site at zimmerbiomet.com/reimbursement.

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SAMPLE LETTER

(Date)

Attn: (Contact Name)
(Title)
(Insurance Company Name)
(Address)

Re: (Patient's Name)
Date of Birth:
Dates of Service:
Group Number:
Subscriber/Policy Number:

Dear (Contact Name):

On (date of service), I performed a (name of procedure) on the above-mentioned patient. (Patient's Name) was diagnosed with (Diagnosis). This patient also has (List any associated symptoms or co-morbidities). (If applicable, include additional information such as alternative treatments that have failed and what health problems may have occurred if the patient did not undergo the procedure. Describe anticipated outcomes and the medical benefits of the treatment).

There is no specific CPT code for this procedure; therefore, I am submitting the following unlisted procedure code (insert CPT code and descriptor). This procedure may be reasonably compared to the existing CPT code (code number and description) in terms of physician work and practice expense. (Define what the procedure entailed and how much more/less difficult it was than the comparable CPT code).

My charge for (the comparator CPT code) is $_____. I estimated the charge for the submitted unlisted procedure to be (list percentage that current procedure is less or more difficult than the comparator code) for the reasons mentioned above. Therefore, I have submitted a charge of $_____ for this procedure. Attached, please find a detailed copy of my operative report, office notes, published articles supporting this procedure and a claim form for (patient's name).

Sincerely,

(Physician's Signature)
(Practice Name)