

# Coding and Reimbursement Strategies: Using an Unlisted Code for Endoscopic Skull Base Surgery

Kim Pollock, RN, MBA, CPC

Mary LeGrand, RN, MA, CCS-P, CPC

The American Medical Association's Current Procedural Terminology® (CPT) codes for reporting medical services and procedures performed by physicians must be used to bill services to third party payers. The contemporary practice of medicine is occasionally ahead of the CPT code system and an accurate code may not always exist for the procedure performed; this is true for reporting most endoscopic/endonasal skull base surgery procedures.

## Coding Issues

Only one CPT code exists for an endoscopic skull base procedure—62165, *Neuroendoscopy, intracranial; with excision of a pituitary tumor, transnasal, or trans-sphenoidal approach*. Unlike the skull base surgery codes that include separate codes for the approach and definitive procedure, CPT 62165 includes the approach, tumor resection, and closure. Modifier 62 (two surgeons) is appended to 62165 when performed as co-surgery involving the otolaryngologist (ORL) and neurosurgeon (NS) to show that neither surgeon performed the entire procedure code.

The existing open (involving a skin incision) skull base surgery CPT codes were introduced to the CPT code system in 1994. Endonasal/endoscopic skull base surgery is relatively new and performed in a limited number of organizations. Therefore, endonasal/endoscopic skull base procedures, except the endoscopic resection of a pituitary tumor (62165), do not have a CPT code. Both the AAO-HNS and the American Association of Neurological Surgeons agree it is **not accurate to use the existing skull base surgery CPT codes for endonasal/endoscopic procedures** because the existing codes describe an open procedure involving skin incision(s).

## Current Coding Landscape

Many otolaryngology and neurosurgery practices have implemented a successful

coding and reimbursement strategy for performing endoscopic skull base surgery procedures together. We have found that many payers fail to recognize, and appropriately reimburse, claims where both surgeons report the same unlisted code with modifier 62 (e.g., 64999-62). Also, CPT guidelines state it is not appropriate to append a modifier to an unlisted code because an unlisted code does not describe a specific procedure.

Because each surgeon is performing his or her own separate procedure in endoscopic/endonasal skull base surgery, much like in the use of the existing skull base surgery codes, we recommend each surgeon report his or her own unlisted CPT code (ORL-31299, NS-64999). **It is not accurate to report individual component codes (e.g., endoscopic sinus surgery, septoplasty) instead of an unlisted code for endoscopic skull base surgery as this is not in line with CPT coding guidelines.**

## Using an Unlisted Code

Each unlisted CPT code is used to describe the actual work by each surgeon. Consider an endoscopic transnasal approach to the anterior cranial fossa, intradural resection of a clival chordoma, with dura repair and septal flap closure. In this scenario, the ORL assists the NS by holding the endoscope and vice versa.

The otolaryngologist reports 31299 (*Unlisted procedure, accessory sinuses*) for his or her portion of the procedure and this code encompasses the ORL's work of the transnasal approach, entering the skull base, but not the dura, assisting the neurosurgeon during the dural opening and tumor resection, and then performing the closure using a local flap.

Use a "base" or similar existing comparison CPT code to determine the ORL's fee for 31299. For example, the base code might be 61580 (*Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration*) for the above example of the clival chordoma endoscopic

resection. The ORL fee for 31299 would include his or her assistant surgeon activity (modifier 80 or 82) on the NS's base code.

## Repair of the Dura/Closure

Closure of the dura is included in the unlisted procedure code reported just as it is part of the usual skull base surgery definitive procedure codes (e.g., 61601). Do not use codes such as 61618 or 61619 (secondary repair of cerebrospinal fluid (CSF) leak codes) as a comparison or base code for the unlisted code billed. A return to the operating room subsequent to the initial procedure, for repair of a CSF leak, may be separately reported.

Additionally, CPT guidelines include surgical wound closure in the open resection/excision definitive procedure skull base code. However, if graft material is harvested through a separate surgical exposure, then a separate graft harvest code may be reported.

**It is not appropriate to report 15750 (Flap; neurovascular pedicle) for a nasolabial flap.** CPT says the following about 15750: "This code includes not only skin, but also a functional motor or sensory nerve(s). The flap serves to reinnervate a damaged portion of the body dependent on touch or movement (e.g., thumb)." The nasolabial flap is created through the same surgical exposure as the primary procedure so it would be included in the primary procedure code.

## Postoperative Care

There is no defined postoperative global period for an unlisted code; therefore, the fee for the unlisted code may reflect a zero-day postoperative global period. Doing so allows the surgeon to separately report all postoperative follow-up care in the hospital, and in the office, including a sinus debridement (31237) and/or nasal endoscopy (31231). The fee for any comparison or base code(s) include a 90-day global period, therefore, the surgeon may want to decrease his/her fee for the unlisted code. Alternatively, the surgeon may set his/her fee for the unlisted code to reflect a

90-day postoperative global period similar to the open skull base code(s) used as the comparison or base code(s).

**Reimbursement Issues**

Many payers do not have a strategy for reimbursing unlisted CPT codes. KarenZupko & Associates, Inc., recommends the following actions to ensure optimal reimbursement for these services.

- Make sure your managed care contracts include a clause requiring payers to reimburse a specific percentage of your billed charge since unlisted codes do not have an assigned Medicare relative value unit (RVU) or payment amount.
- Make an appointment for both specialty surgeon(s) to meet with the medical directors and provider relations representatives (together at the same meeting) of your major payers and present a professional PowerPoint talk with a couple

of patient case studies. Also, show how performing the procedure endoscopically results in lower cost and higher quality of care.

- **Use the letter that follows as one of the following tools:** 1) a written prior authorization letter as part of the approval process prior to surgery, 2) a cover letter with the ORL claim submission, or 3) as an appeal letter for a claim denial. Customize the letter to meet your specific need and patient case.
- It is beneficial to bill and collect for both specialties out of a separate, combined billing area or provider listing in the practice management system when both specialties are in the same practice. This allows separation of these combined specialty cases resulting in easier data analysis. For example, while Medicare may not provide significant additional payment for an unlisted code, we have

found that other payers do. One can easily calculate the average payment per case if these services are billed from a separate billing area or provider listing. The funds can also be more easily divided in a manner equitable to both specialties if desired.

**Conclusion**

Advancements in technology and clinical care are crucial in medicine, although the associated billing and reimbursement practicalities may be challenging. A strategy for accurate coding and optimal reimbursement is critical for otolaryngologists and neurosurgeons who perform endoscopic skull base surgery. 

*Kim Pollock and Mary LeGrand are consultants with KarenZupko & Associates, Inc., a Chicago-based physician practice management consulting company. Both are instructors for the AAO-HNSF/KZA coding and reimbursement workshops.*

**Sample Prior Authorization, Cover Letter, or Appeal Letter for the Otolaryngologist’s Use of an Unlisted CPT Code for Endoscopic/Endonasal Skull Base Surgery**

To Whom It May Concern:

Attached is a copy of Dr. \_\_\_\_\_’s operative note and CMS 1500 claim form to support the use of an unlisted Current Procedural Terminology® (CPT) code for the procedure(s) performed. There are no CPT codes for endoscopic skull base surgery; therefore, I used CPT 31299 (unlisted procedure, nervous system) for my endoscopic definitive procedure of the skull base tumor resection and closure.

The CPT guidelines instruct physicians not to select a CPT code that merely approximates the service provided. Additionally, CPT guidelines state if no such procedure or service exists, then the appropriate unlisted procedure or service code is reported. We are following CPT guidelines by reporting an unlisted CPT code, 31299, because the current skull base CPT codes do not describe an endoscopic/endonasal procedure.

The following table, below left, shows the procedures performed and represented by the CPT code billed and the surgeon’s fee using the appropriate unlisted code. The table below on the right shows a comparison to the current “open” skull base surgery CPT code and our associated fee so you will understand how we derived our charge for this patient’s procedure.

[Add the following statement if the fee reflects a zero-day postoperative global period: Please note that there is no postoperative global period assigned to unlisted CPT codes; therefore, I will be separately reporting all necessary follow-up care including hospital care (9923x), office visits (9921x),

endoscopic sinus debridements (31237), and nasal endoscopy (31231).]

[Add the following statement if the fee reflects a 90-day postoperative global period: Please note that I have included in the fee all postoperative care for 90 days as is included in the comparative base open CPT code(s) listed above. This includes at least three hospital days and two office visits with endoscopic sinus debridements performed bilaterally (31237-50).]

Procedure Performed/Unlisted CPT Code/Our Fee	Comparative Base Open CPT Code(s)/Our Fee
CPT 31299 Unlisted procedure, nervous system (List name of endoscopic procedure here as written by the physician on the operative note)  Fee: \$	CPT (list the codes, descriptions, and fees for the codes used in comparison)  Fee: \$

Thank you in advance for kindly processing this claim in an expeditious and appropriate manner.

Sincerely,  
Dr. Otolaryngologist