Payment Policy: Unlisted/Unspecified Procedure Codes (Commercial & Medicare)

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
R20190015	5/01/2020	RPC (Reimbursement Policy Committee)

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY:

ConnectiCare has policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. ConnectiCare will inform you of new policies or changes in policies through updates to the Provider Manual and/or provider news. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in ConnectiCare's policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by ConnectiCare due to programming or other constraints; however, ConnectiCare strives to minimize these variations.

ConnectiCare follows coding edits that are based on industry sources, including, but not limited to; CPT guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. ConnectiCare uses industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how ConnectiCare handles specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, ConnectiCare may deny the claim and/or recoup claim payment.

Overview

Some procedures or services performed by providers or facilities may not have a valid, more descriptive CPT or HCPCS code assigned. A procedure/service may not have a CPT or HCPCS code if it is new, rare or unusual. Unlisted codes are assigned when submitting claims for procedures/services where a CPT/HCPCS code is not otherwise specified.

According to the AMA (American Medical Association) instructions for the CPT Code Set, select the names of the procedure/service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such code exists, then report the service using the appropriate unlisted procedure/service code. The unlisted code must be from the appropriate anatomic section of codes. Any procedure/service must be adequately documented in the medical record.

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Criteria

Clinical documentation is required for all unlisted codes submitted for reimbursement. The clinical documentation will be reviewed for appropriate coding, existence of a more appropriate code, coverage, reimbursement allowance and prior notification, if needed. ***Claims submitted without supporting clinical documentation will be denied.***

Supporting clinical documentation should include:

- Complete description of the procedure
- Whether the procedure was performed independent from other services provided or if it was performed at the same site or through the same surgical opening
- Any extenuating circumstances which may have complicated the service or procedure
- Time and equipment necessary to provide the service
- The number of times the service was provided
- NDC#, dose and route of administration for unlisted drug codes
  (see list of Route of Administration Abbreviations below)
- Physician Order and/or Prescription and Invoice for unlisted DME/supply codes

Guideline for documentation requirements:

Procedure Code	Example	Documentation Requirements
Surgical procedures: all unlisted codes within the range of 10021-69990	• CPT Code 19499 – unlisted procedures, breast	Operative or procedure report
Radiology/imaging procedures: all unlisted codes within the range of 70010-79999	• CPT Code 76496 – unlisted fluoroscopic procedure (e.g. diagnostic, interventional)	Imaging report
Laboratory and pathology procedures: all unlisted codes within the range of 80047-89398	• CPT Code 84999– unlisted chemistry procedure • CPT Code 89240 – unlisted miscellaneous pathology test • CPT Code 81479 – unlisted molecular pathology procedure	Laboratory or pathology report
Medical procedures: all unlisted codes within the range of 90281-99607	• CPT Code 92499 – unlisted ophthalmological service or procedure	Office notes and reports
Unlisted HCPCS codes	• G6021 – unlisted procedure, small intestine	Operative or procedure note
Unclassified drug codes	• J3490 – Unlisted drugs • J3590 – Unclassified biologics • J7999 – Compounded drug, not otherwise classified • J8499 - Prescription drug, oral, nonchemotherapeutic, NOS • J9999 – Not otherwise classified, antineoplastic drugs • A4641 – Radiopharmaceutical, diagnostic, not otherwise classified	Operative or procedure note to include NDC#, dose and route of administration
Unlisted DME HCPCS codes	• A9999 – Miscellaneous DME supply or accessory, NOS	Physician prescription or order, report and invoice for unlisted DME/Supply code

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Route of Administration (Drugs) Abbreviations:

📎	**Route of Administration Abbreviations (Drugs)**

Billing Guidelines:

- Please submit paper claims for unlisted procedure codes; with the exception of unlisted drugs (see above requirements). Electronic claims for unlisted procedures/services may be denied as attachments are not accepted electronically at this time
- The "Claim Submission for Unlisted Procedure or Service Code Special Report" form must be completed and included with the claim as well as any documentation requirements listed above
- Claims submitted with unlisted procedure codes without supporting documentation will be denied
- Claims submitted with an unlisted procedure code will be denied if determined that a more appropriate procedure/service code is available
- No additional reimbursement is provided for special techniques/equipment submitted with an unlisted procedure code
- Unlisted procedure codes appended with a modifier may be denied.
  - *Exception: Unlisted codes for DME, orthotics, and prosthetics require appropriate NU, RR or MS modifier*
- When performing two or more procedures that require the use of the same unlisted CPT code, the unlisted code should only be reported once to identify the services provided
  - *Excludes unlisted HCPCS codes; for example: DME/unlisted drugs*

Unlisted Procedure or Service Code – Claim Submission Forms:

📎	**Unlisted Procedure/Service Code Form (Commercial)**
📎	**Unlisted Procedure/Service Code Form (Medicare)**

References:

- American Medical Association, Current Procedural Terminology (CPT®) Professional Edition and associated publications and services
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

Revision history:

DATE	REVISION
5/2020	• Updated documentation requirements to apply to all unlisted CPT/HCPCS codes • Updated policy with current Commercial & Medicare "Unlisted Procedure/Service Code Claim Form • Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number
1/2001	• Original Policy