Select Health

CODING/REIMBURSEMENT POLICY

UNLISTED/UNSPECIFIED CODES

Policy # 08
Implementation Date: 1/1/06
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Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

The *CPT Professional* includes unlisted codes to identify services or procedures not described by other HCPCS/CPT codes. These unlisted procedure codes are generally identified as XXX99 or XXXX9 codes and are located at the end of each section or subsection of the CPT manual. If a physician provides a service that is not accurately described by other HCPCS/CPT codes, the service may be reported using an unlisted procedure code. However, it may be more appropriate to report the best fit HCPCS/CPT code with a reduced services modifier if all components of the procedure were not performed. Since unlisted procedure codes may be reported for a very diverse group of services, the NCCI program generally does not include edits with these codes.

Occasionally a procedure billed with an unlisted code may include enough elements to determine a fee schedule using a comparable CPT/HCPCS code. A permanent fee scheduled is then established to maintain payment consistency. Select Health will identify appropriate reimbursement based on services performed, including using fee schedules for comparable codes.

Terms

Unlisted procedure codes may be partially identified by one of the following terms in the CPT/HCPCS code description:

- Not Elsewhere Classified (NEC)
- Not Elsewhere Specified (NES)
- Not Otherwise Classified (NOC)
- Not Otherwise Specified (NOS)
- Not Listed
- Non-Specified
- Unclassified
- Unlisted
- Unspecified

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Select Health requires a provider to submit all necessary definitions or descriptions of the item, procedure, or service billed with an unlisted code. Providers are responsible for determining if an item, procedure, or service billed with an unlisted code requires preauthorization, and to obtain preauthorization before services are rendered to the Select Health member. Due to continual changes in regulatory, CMS and state guidelines, and provider contracts, additional codes may apply and are subject to change.

Billing Guidance and Payment Procedure

A. Unlisted procedure codes may be reported only when no specific CPT/HCPCS code adequately describes the item, procedure, or service.
B. Unlisted procedure codes may be billed with modifier(s) if appropriate.
C. Select Health allows reimbursement for valid unlisted procedure codes on commercial plans when supported by appropriate documentation.
D. In most circumstances, claims submitted with an unlisted procedure code are reviewed to determine if a more appropriate CPT/HCPCS code is available for the item, procedure, or service. If a more appropriate procedure code is available that suitably describes the item, procedure, or service, the claim may be denied.
E. Special techniques/equipment submitted with an unlisted procedure code will not increase procedure reimbursement.
F. The use of robotic or computer-assisted surgical navigation submitted with an unlisted procedure code will not increase procedure reimbursement.
G. Payment for drugs and biologicals billed with an unlisted procedure code will be determined by the plan, not the number of units billed.

Documentation Guidelines

According to CMS guidelines, providers should submit sufficient documentation that support claims are billed appropriately. Ultimately it is the provider's responsibility to submit preauthorization(s) with supporting documentation within the appropriate timeframe. Failure to do so can result in the delaying or denial of claims. Documentation submitted should include, but is not limited to:

1. Signed medical records (i.e. operative or office notes, imaging, laboratory, pathology reports, etc.)
2. Complete and accurate description of the item, procedure, or service billed for reimbursement.
3. The extent of the need for the item, procedure, or service.
4. When billing an unlisted code more than once, the additional billing may require using a modifier. Documentation should support the number of units and modifier(s) billed.
5. Whether the procedure was performed independent of other services, or if it was performed through the same surgical opening or at the same surgical site.
6. Qualifying circumstances that support billing the unlisted code.
7. For Durable Medical Equipment, prosthetic, or orthotic (DMEPOS), the manufacturer's invoice for the unlisted item. The invoice should include the product number (UPN) and a name and description of the item.
8. For unlisted drug codes, include (but not limited to):
    - Manufacturer invoice with the entire drug name or description
    - National Drug Code (NDC) number
    - NDC unit(s) to indicate the quantity of drug administered
    - Dosage for the unlisted drug or biological
    - NDC product package size unit of measure (e.g., UN, ML, GR, F2)
    - NDC qualifier
    - Modifier(s), if appropriate
    - See the FDA National Drug Code Directory for additional assistance
9. The provider should supply a comparable CPT/HCPCS code(s), comparable RVU, and/or a portion of a logically comparable charge to reflect suggested pricing of the unlisted code. Select Health will consider this information during pricing determination.
10. The required information must be clearly marked and legible.

Select Health reimburses unlisted CPT and HCPCS Level II codes as well as some codes that do not have an established CMS Relative Value Unit at a percentage of billed charges except in the following situations:

1. An RVU calculation can be found for the determination of a specific fee.
2. Adequate local, regional, or national claims experiences exist, which allows the determination of a specific fee.

3. The procedure for which the code is used is so similar to another procedure which has a listed CPT, HCPCS Level II code, or other accepted code and fee that an equitable fee can be established (i.e., unlisted laparoscopic procedure vs. equivalent open procedure).

Adequate local, regional, or national pricing for specific procedures exist, which allows the determination of a base value to derive a specific fee.

SELECT HEALTH MEDICARE (CMS)

Select Health Medicare will follow the Commercial Policy with the addition that all unlisted codes require prior authorization. Select Health allows reimbursement for valid unlisted procedure codes with preauthorization on government plans when supported by appropriate documentation.

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care will follow the Commercial Policy with the addition that all unlisted codes require prior authorization. Select Health allows reimbursement for valid unlisted procedure codes with preauthorization on government plans when supported by appropriate documentation.

Sources

1. Johns Hopkins Unlisted Codes policy, effective 12/30/23. https://www.hopkinsmedicine.org/-/media/johns-hopkins-health-plans/documents/policies/unlisted-codes-professional.pdf
2. NCCI (2024, January 1) General Correct Coding Policies for Medicare National Correct Coding Initiative Policy Manual, Chapter 1. Retrieved on October 11, 2024.