Unlisted and Unspecified Procedure Codes

LOB(s):	State(s):
☒ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon* ☐ *Washington*

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

There are services or procedures performed by providers that do not have specific Current Procedure Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, which are often used to represent new and emerging technologies. When submitting claims for these services or procedures that are not otherwise specified, providers must use a group of "unspecified" or "unlisted" codes, which will be referred to in this document as "unlisted codes." Many unlisted codes end in – 99.

Unlisted codes provide the means of reporting and tracking services, procedures, laboratory tests, medications, and durable medical equipment purchases (collectively referred to here as "procedures") until a more specific code is established. Any service or procedure must be adequately documented in the medical record.

Criteria

I. Unlisted HCPC/CPT Codes Supporting Documentation Requirements

Commercial, Medicaid and Medicare

Unlisted codes will only be used if no code exists to describe the procedure, service or supply. To support the billing of an unlisted code, it is necessary for the provider to submit supporting documentation when filing a claim. Pertinent information should include:

- A clear description of the need for use of the unlisted code and why a specific code is not sufficient
- A written operative report or similar detailed description of procedure performed
- Whether the procedure was performed independent from other services provided, or if it was performed at the same surgical site or through the same surgical opening
- Any extenuating circumstances which may have complicated the procedure
- Time, effort, and equipment necessary to provide the procedure
- The number of times the procedure was performed

Submitting Supporting Documentation

Providers will designate the portion of the report that identifies the test or procedure associated with the unlisted code. Required information must be legible and clearly marked.

II. Unlisted HCPCS/CPT Code Review

Unlisted codes are subject to benefit limitations, contract limitations, and claim submission timeframes, like all other CPT/HCPCs codes.

PacificSource follows a prior authorization algorithm to determine if an unlisted code requires a prior authorization. A provider can review PacificSource's Provider Authorization Grid to verify if an unlisted code requires a prior authorization.

Commercial

An unlisted code may be initially reviewed by either the Utilization Management (UM) Team or Claims Team, depending on the specific code review requirements as determined by PacificSource.

- If a claim is received by the Claims Team and a Claim Analyst is not able to determine if adequate documentation is attached, the Claims Team will forward to the Health Services Utilization Management (UM) Staff for further documentation review.
- If the UM Team received a request and is unclear if a specific code should be used instead of an unlisted code, the UM Staff reaches out to the Claims Team for clarification or assistance in making a determination.

Coverage of an unlisted code may be denied by either the UM or Claims Team for the following claim denial reasons:

- The submitted medical documentation describes a service or procedure with an appropriate and specific CPT/HCPCS code, indicating an unlisted code is not appropriate
- Medical documentation has not been submitted or is insufficient to make a claim determination
- A service, procedure, device, or treatment determined to be experimental, investigational, or unproven is identified on the New and Emerging Technologies – Coverage Status policy

Coverage of an unlisted code may be denied only by UM Team for the following reasons:

- Medical documentation has not been submitted or is insufficient to make a medical necessity determination by a Medical Director
- A service, procedure, device, or treatment is determined to be not medically necessary by a Medical Director
- A service, procedure, device, or treatment is determined to be experimental, investigational, or unproven by a Medical Director

Medicaid and Medicare

If the PacificSource Community Solutions and PacificSource Medicare Claims Teams receive unlisted codes without descriptions or comparable codes, the claim is denied due to lack of documentation.

IV. Payment and Provider Billing

A. Maximum Allowable Payment

Commercial

When the claim and submitted documentation meet criteria for payment, Claims Staff will set maximum allowable payment for the unlisted code on the claim:

- For non-contracted providers and for contracted providers, where contract language references a specific fee schedule (e.g., PacificSource default), a Claim Analyst will determine a similarly complex, specific code whose maximum allowed payment will be set as the maximum allowed for the unlisted code on the current claim.
- When contract language references only Relative Value Units (RVU) and percent of charges, specified Claims Staff will set allowable price based on the percent of charges specified in the provider's contract.

Medicaid and Medicare

When the claim and submitted documentation meet criteria for payment, Claims Staff will set maximum allowable payment for the unlisted code on the claim:

- PacificSource Community Solutions and PacificSource Medicare Claims Teams pay a PacificSource default fee per the Medicaid and Medicare contract for claims received with unlisted codes that include a description for both contracted and non-contracted (out-of-network) providers.

B. Provider Billing and Documentation Guidelines

Commercial

When PacificSource Claims Team identifies a specific code that most closely approximates the service performed, the unlisted code will be reimbursed at the designated Relative Value Unit (RVU), for that specific code.

- No additional reimbursement will be provided for special techniques or equipment submitted with an unlisted code.
- Unlisted 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, such as DME or unlisted drugs).

Definitions

Experimental, investigational, or unproven - a procedure, treatment or device which does not have scientific evidence to support medical effectiveness.

Related Policies

Medically Necessity Reviews

New and Emerging Technologies – Coverage Status

References

American Medical Association, Standard Edition. Current Procedural Terminology (CPT®) 2023.

Centers for Medicare and Medicaid Services (CMS). (May 27, 2022). *Medicare Claims Processing Manual Chapter 26 - Completing and Processing Form CMS-1500 Data Set.* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf

Centers for Medicare and Medicaid Services (CMS). (January 30, 2018). CMS Standard Companion Guide Transaction Information. Instructions related to the 837 Health Care Claim: Professionals based on ASC X12 Technical Report Type 3 (TR3), version 005010A1. Companion Guide Version Number: 3.0. https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/5010A1837BCG.pdf

Optum, EncoderPro. (2023). HCPCS Level II. A resourceful compilation of HCPCS codes.

Oregon Administrative Rules (OARs). Oregon Health Authority. Health Systems: Medical Assistance Programs – Chapter 410
https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87

Appendix

Policy Number:

Effective: 1/1/2021 **Next review:** 5/1/2025

Policy type: Enterprise

Author(s):

Depts.: Health Services

Applicable regulation(s): OAR 410-120-1280(9)(c)

Commercial OPs: 11/2024

Government OPs: 10/2024