Payment Policy: Unlisted Procedure Codes

Reference Number: LA.PP.009
Product Types: Medicaid & Ambetter
Last Review Date: 06/2023

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Some services or procedures performed by providers may not have specific Current Procedure Codes (CPT) or HCPCS codes. When submitting claims for these services or procedures that are not otherwise specified, unlisted codes are designated. Unlisted codes provide the means of reporting and tracking services and procedures until a more specific code is established.

Application
This policy applies to claims containing procedure codes that are unlisted. Unlisted procedure codes should not be used when a more descriptive procedure code representing the service provided is available.

Policy Description
According to the Instructions for Use of the CPT Code book in the Current Procedural Terminology, select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service performed. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code. When necessary, any modifying or extenuating circumstances are added. Any service or procedure should be adequately documented in the medical record.

Reimbursement
- Claims submitted with unlisted procedure codes and without supporting documentation are denied.
- Claims submitted with unlisted procedure codes are denied if after review, it is determined that a more appropriate procedure code is available.
- Additional reimbursement may not be provided for special techniques/equipment submitted with an unlisted procedure code.
- Unlisted procedure codes with a modifier appended are reviewed and may be denied
- 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).
- If the services bundle, the provider is sent a letter indicating such and the additional payment is denied.
- If the procedure is experimental, an authorization is required.

Documentation Requirements
Certain supporting documentation is required when filing a claim that includes unlisted procedure codes, because those codes do not describe or identify a specific procedure or service. That supporting documentation should contain the following pertinent information:

- A clear description of the nature, extent, and need for the procedure or service
- A detailed report that clarifies whether the procedure was performed independently from other services, or if it was performed at the same surgical site or through the same surgical opening as another procedure
- A description of an extenuating circumstances which may have complicated the service or procedure
- An account of the time, effort and equipment necessary to perform the procedure or provide the service
- A description of the number of times the procedure was performed or the services were provided

When submitting supporting documentation, designate the portion of the report that identifies the test or procedure associated with the unlisted procedure codes. Required information must be legible and clearly marked. Refer to the table below for the guidelines on documentation requirements.

Procedure Code Category	Documentation Requirements
Surgical Procedures: All unlisted codes within the range of 10021-69990 and/or by report	Operative or Procedure Report
Radiology/Imaging Procedures: All unlisted codes within the range of 70010-79999 and/or by report	Imaging Report
Laboratory and Pathology Procedures: All unlisted codes within the range of 80047 -89398 and/or by report	Laboratory or Pathology Report
Medical Procedures: All unlisted codes within the range of 90281-99607 and/or by report	Office Notes and Reports
Unlisted HCPCS Codes	Operative or Procedure Report
Unclassified Drug Codes	Provide the NDC number with full description/name and strength of the drug and service units
Unlisted DME HCPCS Codes	Provide narrative on the claim; also, if applicable, provide invoice or UPN information.

References

1. *Current Procedural Terminology (CPT®)*, 2022

2. *HCPCS Level II*, 2022
3. *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 2022
4. *ICD-10-CM Official Draft Code Set*, 2022
5. *CMS Pub. 100-04, Medicare Claims Processing Manual, Chapter 4/180.3, Unlisted Service or Procedure. Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*

Revision History	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
Annual Review; Updated clinical to payment policy in "Important Reminder" section	08/25/2022	
Annual Review; updated dates in reference section	6/16/2023	9/13/2023

Important Reminder

This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible

for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.