REIMBURSEMENT POLICY

Unlisted Procedure Code Policy

Active

Policy Number: General Coding – 005
Policy Title: Unlisted Procedure Code Policy
Section: General Coding
Effective Date: 12/02/14

Description

This policy addresses coverage and reimbursement for services that are submitted with an unlisted HCPCS (Level I, a.k.a., CPT, and Level II, alpha-numeric codes) code.

Definitions

Some services or procedures performed or supplied by practitioners might not have a specific HCPCS that adequately describes the procedure or service. When submitting claims for these services or procedures, unlisted codes may be used.

Unlisted codes are identified in part by one of the following terms in the HCPCS description:

- Not Otherwise Classified;
- Unlisted;
- Not Listed;
- Unspecified;
- Unclassified;
- Not Otherwise Specified;
- Non-specified;
- Not Elsewhere Specified;
- NEC
- NOS

Policy Statement

Unlisted codes should only be used if no code exists to describe the procedure, service or supply.

Submit the unlisted code from the related HCPCS section and furnish the appropriate information based on the type of unlisted code.

At minimum, a complete narrative description of or identification of the service or item must be submitted or supplied. This information is entered in the electronic claim in the NTE segment:

- 837P: Loop 2400, Segment NTE
- 837I: Loop 2300, Segment NTE

If not included or attached, Blue Cross will send out the request for additional information and deny the claim simultaneously. However, once the additional information is received, the claim will be reprocessed.

Claims submitted with unlisted codes may be subject to denial when a definitive code exists.

Provider agrees to use unlisted procedure codes only when no code exists for the service being provided. Reimbursement for unlisted codes will be determined on one of the following methodologies:

- 85% of the Average Wholesale Price (AWP) for drug codes
- Percentage of Provider's Regular Billed Charge (55% of charge for Commercial and 35% of charge for Medicare)
- Invoice cost
- Allowance of similar code (procedure/item)
- Wholesale Acquisition Cost (WAC) for gene therapy drugs– see General Coding-074-Cellular and Gene Therapy Products reimbursement policy

Documentation Submission

Any service or procedure should be adequately documented in the medical record.

Because unlisted and unspecified procedure codes do not describe a specific procedure or service, it is necessary to submit supporting documentation when filing the claim or on request. Pertinent information should include:

- A clear description of the nature, extent, and need for the procedure or service.
- 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 service or procedure.
- Time, effort, and equipment necessary to provide the service.
- The number of times the service was provided.

When submitting supporting documentation, identify the portion of the report (such as underlining or highlighting the entry) that identifies the test or procedure associated with the unlisted procedure code. Required information must be legible and clearly marked. (Refer to the guideline below for documentation requirements.)

Procedure Code Category	Documentation Requirements
Surgical Procedures	Operative or procedure report
Radiology/imaging procedures	Imaging Report
Laboratory and pathology procedures	Laboratory or pathology report
Medical Procedures and Behavioral Health Services	Office notes, chart notes and reports

Unclassified drug codes	Provide the National Drug Code (NDC) number with full description/name and strength of the drug and dosage
Unlisted DME HCPCS codes	Provide narrative on the claim, Manufacturers Suggested Retail Price (MSRP)

When billing an unlisted code, the unit should always be one (1).

Coverage

Claims submitted with an unlisted procedure code will be denied if determined an appropriate procedure or service code that most closely approximates the service performed is available.

Claims billed with unlisted procedure codes and without narrative information and/or supporting documentation will be denied.

Unlisted procedure codes (other than DME, orthotics and prosthetics) appended with a modifier may be denied.

Unlisted codes for DME, orthotics and prosthetics require the appropriate modifier to differentiate rental, purchase and repair or replacement of DME.

Multiple units will not be allowed for any unlisted code. Only one (1) unit may be submitted.

No additional reimbursement is provided for special techniques/equipment submitted with an unlisted procedure code.

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.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier: N/A

ICD Diagnosis: N/A

ICD Procedure: N/A

HCPCS: Unlisted codes are identified in part by one of the following terms in the HCPCS description:

- Not Otherwise Classified;
- Unlisted;
- Not Listed;
- Unspecified;
- Unclassified;
- Not Otherwise Specified;
- Non-specified;
- Not Elsewhere Specified;
- Not Elsewhere;
- NOS
- NOC

Revenue Codes: N/A

Deleted Codes: N/A

Policy History

Initial Committee Approval Date: December 02, 2014

Code Update: N/A

Policy Review Date: April 6, 2016
August 30, 2017
January 27, 2020
January 4, 2021

Cross Reference: General Coding: Cellular and Gene Therapy Products 074