

Coding Policy Policy and Procedure		
SUBJECT: Coding Policy 27.0 Billing Guidelines for New or Unlisted CPT and HCPCS Codes	DEPARTMENT: Health Care Services	
ORIGINAL EFFECTIVE DATE: 01/2001	DATE(S) REVIEWED/REVISED: 03/02-01/09, 01/10, 06/10, 01/11, 01/12, 01/13, 01/14, 01/15, 01/16, 04/16, 01/17, 01/18, 02/18, 01/19, 01/20, 01/21, 01/22, 01/23	
APPROVED BY: Coding Policy Review Committee	NUMBER: MC 27.0	PAGE: 1 of 3

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

All Lines of Business
Health Plan Providers

POLICY:

CPT or HCPCS codes which do not have a relative value unit (RVU) established by CMS or other established price may be priced by Providence Health Plan (PHP). Newly published CPT or HCPCS codes for the current year may be priced and incorporated into pre-existing fee schedules. Unlisted codes are priced based on work documented in the procedure note and/or pricing of comparable procedures.

Prior authorization must be obtained for unlisted codes if a medical policy exists that says prior authorization is required for that procedure. Providers are advised to check for medical policies before performing procedures billed with unlisted codes. **Supporting documentation is required for all unlisted codes, even if the procedure has been prior authorized.**

Unless determined otherwise by medical review, all unlisted codes in the range 10000-69999 are assigned a 90-day global period. When an unlisted code is used to report a minor procedure, providers may submit an appeal requesting that a 10-day global period be assigned for that procedure. See also Coding Policy 12.0 (Global Surgical Package).

Supporting Documentation Requirements for Unlisted Codes

Because unlisted codes do not describe a specific procedure or service, providers must submit supporting documentation when filing claims for unlisted codes. Required information includes:

- A copy of documentation to support the service with the portion of the report that identifies the test or procedure being reported underlined. (Do not use a highlighter.)
- A clear description of the nature, extent, and need for the procedure or service.
- Any extenuating circumstances which may have complicated the service or procedure.
- Time, effort, and/or equipment necessary to provide the service.
- The provider may also give the code for a comparable procedure as a suggestion for pricing the unlisted code. (PHP may or may not use this information for pricing.)

Required information must be legible and clearly marked. (Refer to the grid on Page 2 of this policy for documentation requirements.)

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Procedure Code Category	Example	Documentation Requirements
Surgical procedures: All unlisted codes within the range of 10000-69999	CPT 20999 "Unlisted procedure, musculoskeletal system, general"	Operative or procedure note (underline the portion of the report that identifies the unlisted procedure)
Radiology/imaging procedures: All unlisted codes within the range of 70000-79999	CPT 78099 "Unlisted endocrine procedure, diagnostic nuclear medicine"	Imaging report
Laboratory and Pathology procedures: All unlisted codes within the range of 80000-89999	CPT 84999 "Unlisted chemistry procedure"	Laboratory or Pathology report
Medical Procedures: All unlisted codes within the range of 90000-99999	CPT 99499 "Unlisted evaluation and management service"	Office notes and reports
Unclassified drug codes (All unlisted codes within the range of J3490-J9999, Q4082, S4993, S5000, 90399, 90749)	HCPCS J3490 "Unclassified drugs"	1. Drug name and NDC number 2. Dosage administered
Unlisted DME/HCPCS codes	HCPCS E1399 "DME, miscellaneous"	Provide narrative on the claim.

Billing Guidelines for Unlisted Codes

- Because an unlisted code does not describe a specific service or supply, modifiers are not appropriate. With the exception of assistants at surgery and co-surgeons, unlisted CPT codes appended with a modifier may be denied. Modifiers indicating assistant at surgery (80, 81, 82, AS) or co-surgery (62) may be appended to unlisted codes. Payment is subject to medical review.
- Unlisted HCPCS codes for DME, orthotics, and prosthetics require appropriate NU, RR, or MS modifiers.
- When performing two or more procedures that require use of the same unlisted CPT code, the unlisted code should only be reported once to identify all the services provided. (Excludes unlisted HCPCS codes.)
- Unlisted codes submitted without supporting documentation will be denied.

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PROCEDURE:

All unlisted codes are submitted for medical review. Medical Management, Medical Directors, and/or Coding Policy review unlisted codes to determine the following:

- If the procedure or service requested by the unlisted code actually has a specific CPT code that is more appropriate.
- If the procedure or service requested by an unlisted code is medically necessary. This would include determinations of the following:
 1. A medical problem requiring the procedure is addressed in the operative note,
 2. The procedure is appropriate to treat the medical problem,
 3. The procedure is of proven efficacy, and/or the standard of care, and
 4. The facility where the service is performed is appropriate.

Pricing for new codes and/or unlisted codes will be determined based on:

- Current year relative value
- Crosswalk of comparable code
- Crosswalk pricing from one fee schedule to another

If pricing cannot be established, the service will default to payment by discount.

REFERENCE:

CMS/ Medicare Rules and Regulations
 Current Procedural Terminology (CPT)
 HCPCS, Medicare National Level II Codes