

Coding Policy

Unlisted Procedure Codes

CODING POLICY NUMBER: 27

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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”). **The full Company portfolio of current coding policies is available online and can be [accessed here](#).**

POLICY APPLICATION

- Providence Health Plan Participating Providers
- Non-Participating Practitioners
- Commercial
- Medicaid/Oregon Health Plan
- Medicare

POLICY STATEMENT

- I. 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). Unlisted codes are priced on an individual basis. (See the [Procedure](#) section below for methodology.)
- II. Providers are advised to review medical policies before billing procedures reported using unlisted codes.
 - I. 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 Coding Policy 12.0 (Global Surgical Package).

PROCEDURE

DOCUMENTATION REQUIREMENTS

Because unlisted codes do not describe a specific procedure or service, providers must submit complete and legible supporting documentation when filing claims for unlisted codes including the following:

- A detailed description of the procedure or service including the nature, extent, and need. Providers must also include a brief description in the narrative field of the claim form.
- Supporting clinical documentation with the unlisted service clearly identified (i.e. marked, circled, or underlined; do not use a highlighter). See examples in Table 1 below.
- A comparable procedure code when possible. (PHP may or may not use this recommendation for pricing).

Unlisted codes submitted without sufficient supporting documentation will be denied.

Table 1: Clinical Documentation Examples

Procedure Code Category	Example Code	Clinical Documentation
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 Drugs: 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 or an invoice with detailed description of the item/supply

BILLING GUIDELINES

It is not appropriate to select a procedure code that merely approximates the service provided. Unlisted or miscellaneous codes will be considered for reimbursement for medically necessary services when an established code does not exist to describe the service, supply, or drug provided. If an appropriate and valid procedure code exists, the unlisted code will be denied.

Because unlisted codes do not describe a specific service or supply, modifiers are generally not appropriate. Unlisted codes appended with a modifier may be denied, with the following exceptions:

- Unlisted CPT codes may be appended with modifiers indicating assistant at surgery (80, 81, 82, AS) or co-surgery (62).
- Unlisted HCPCS codes for DME, orthotics, and prosthetics require the 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. (This does not apply to unlisted HCPCS codes).

Company requires a concise description of the service or procedure rendered to be included in the narrative field of all claims billing unlisted codes. This description is limited to 70 characters. It is helpful to include how the procedure was performed (e.g., laparoscopic, open, transnasal, with clip, type of graft, etc.), the body area treated, why it was performed, and a comparison code (if applicable). This description must be reported in:

- Item 19 on the CMS-1500 claim form or electronic equivalent, or
- Form locator 80 on the CMS-1450 claim form or electronic equivalent.

It is the responsibility of the provider to ensure all information required to process an unlisted procedure is included. Unlisted codes submitted without a sufficient description of the procedure in the appropriate claim form field may be denied.

MEDICAL REVIEW

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

- Medical Necessity:
 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.
- Coding:
 1. The service reported with the unlisted code does not have a specific CPT or HCPCS code that is more appropriate.
 2. The service is separately reportable.
 3. Appropriate comparable code(s) for pricing

PRICING

Pricing for unlisted codes will be determined on an individual basis. In instances where no pricing is available (based on RVU, fee-schedule, APC rates, etc.), pricing may be established based on comparison to a code representing similar work. **When pricing is based on a comparable code, all edits that apply to the comparable code will also apply to the unlisted code.**

If an appropriate comparable code cannot be identified, the service will default to payment by discount.

REFERENCES

1. Centers for Medicare & Medicaid Services (cms.gov)
2. American Medical Association. Current Procedural Terminology (CPT)
3. Center for Medicare & Medicaid Services, HCPCS Level II Codes

POLICY REVISION HISTORY

Date	Revision Summary
1/2023	Annual review (converted to new template 5/2023). Original policy effective date: 1/2001
11/2023	Annual review for 2024. Updated language to clarify that when a comparable code is used for pricing an unlisted code, all the edits that apply to the comparable code will also apply to the unlisted code.
1/2025	Annual review. No changes to policy.
5/2025	Annual review. Policy name change, simplified documentation requirements, clarified coding and medical review roles, and removed pricing information regarding new codes.
12/2025	Interim Update. Removed prior authorization information. Effective 1/1/2026, the procedure name must be submitted in the narrative field of the claim.