Payment Policy:	**Unlisted Procedure Codes**	
Original Date Approved: 10/26/2017	**Effective Date** 1/1/2018	**Date Revised:** 8/16/2019
Scope: Commonwealth Care Alliance (CCA) Product Lines: ☒ Senior Care Options ☒ One Care		

PAYMENT POLICY SUMMARY:

Some services or procedures performed by providers might not have Current Procedural Terminology codes (CPT) or HCPCS codes. When submitting claims for these services unlisted codes are designated. Use of an unlisted code is common when a provider performs a new procedure or utilizes new technology when no other code adequately describes the procedure or service. Because unlisted procedure codes do not describe a specific procedure or service, it is necessary to submit supporting documentation when filing a claim. CCA will accept unlisted procedure codes when they are accompanied by supportive documentation.

PROVIDER SUPPORTING DOCUMENTATION REQUIREMENTS:

CCA requires that providers submit supporting documentation when filing a claim with an unlisted procedure code. Pertinent information should include:

- A clear description of the nature, extent, and need for procedure or services
- Whether the procedure was performed independent from other services provided, if it was performed at the same surgical site, or 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 highlight the portion of the report that identifies the test or procedure associated with the unlisted procedure code. Required information must be legible and clearly marked.

How to Submit Supporting Documentation:

Claims should be submitted on the applicable industry standard claim form and shall include the following supporting documentation that is required according to the Centers for Medicare and Medicaid Services (CMS):

- Detailed description of the procedure or service
- Comparable CPT/HCPCS code when possible
- Supporting clinical documentation

CCA reserves the right to request an invoice on services that are billed with an unlisted code and the claim exceeds $200.

Address to Send Claims & Supporting Documentation:

Commonwealth Care Alliance
PO Box 22280
Portsmouth, NH 03802-2280

DOCUMENTATION GUIDELINES BY PROCEDURE CODE :

Unlisted Procedure Code Category	Procedure Code / Description	Supportive Documentation Requirements
Evaluation & Management	99499	Office Notes and Reports
Anesthesia	01999	Operative or Procedure Report
Surgical Procedures	15999-69979 (code range)	Operative or Procedure Report
Radiology Procedures	76497-79999 (code range)	Imaging Report
Pathology & Laboratory	81999-89398 (code range)	Laboratory or Pathology Report
Medical Procedures	90399-99600 (code range)	Office Notes and Reports
Unlisted HCPCS Codes	Refer to HCPCS Manual for Coding	Operative or Procedure Report
Unlisted HCPCS DME Codes	Refer to HCPCS Manual for Coding	Provide Narrative on the Claim

CCA will reimburse an unlisted procedure or service based upon a comparable procedure. Supporting documentation will help CCA determine accurate claim reimbursement.

PROVIDER REIMBURSEMENT AND BILLING GUIDELINES:

CCA will reimburse medically necessary and authorized unlisted procedures and services when they are submitted with the appropriate supporting documentation. All claims submitted with unlisted procedure codes are subject to Clinical Review. Claims submitted without supporting documentation may be denied. Billing guidelines include the following:

- Do not append modifiers to unlisted procedure codes
- Unit value should be reported only once to identify the services provided. If more than one procedure is performed that require the use of the same unlisted code it should be reported only once. Documentation should support and detail additional procedures if submitted for reimbursement.
- No additional reimbursement is provided for special techniques/equipment submitted with an unlisted procedure code.
- Relative Value Units (RVU) are not assigned to unlisted procedure codes because the codes do not identify usual procedural components or the effort/skill required for the service.
- CCA will make the payment determination based upon a comparable procedure—Providers will need to gather RVU's, charges, and/or payment for a similar comparable procedure.
- The comparable procedure should have a similar approach and similar anatomical site. It is necessary to provide the RVU's and/or charges for the similar procedure and provide an

explanation of how the current procedure is more or less difficult from the comparable procedure.

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

CCA reserves the right to request preauthorization to complete a retrospective review of services provided. In some instances, medical records may be requested for determination of medical necessity. When medical records or clinical information is requested, all supporting documentation to support medically necessary services should be included for clinical review. If the requested records or clinical information is not received by CCA within 30 days of the request, claims under review will be denied.

CCA reimbursement policies are developed based upon nationally and locally accepted industry standards and coding principles. These policies may be superseded by mandates in provider state, federal, or CMS contracts and requirements. System logic or set up may prevent the loading policies into claims platforms in the same manner as described; however, CCA strives to minimize these discrepancies.

CCA reserves the right to review and revise our policies when necessary. When there is an update, we will publish the most current policy to this site.

REFERENCES:

This policy has been developed through consideration of the following:

*Centers for Medicare and Medicaid Services, CMS Manual System, and other CMS publications and services. (*www.cms.gov*)*

POLICY TIMELINE DETAILS

1. December 2018 Approved
2. Effective date 3/3/2019
3. Annual review and format revision 8/15/2019