PROVIDER REIMBURSEMENT GUIDANCE			
Unlisted Procedure Codes			
Original Date Approved	Effective Date Senior Care Options/One Care	Effective Date Medicare Advantage*	Revision Date
10/26/2017	03/01/2022	03/01/2022	04/27/2023

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options MA
☒ One Care MA
☒ Medicare Preferred – (PPO) MA
☒ Medicare Value - (PPO) MA
☒ Medicare Premier – (PPO) MA**
☒ Medicare Preferred – (PPO) RI
☒ Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO D-SNP) RI

PAYMENT POLICY SUMMARY:

When a provider performs services or procedures that do not have a Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code, unlisted codes are designated for use. This is common when a provider performs a new procedure or utilizes new technology in which no other code adequately describes the procedure or service.

AUTHORIZATION REQUIREMENTS:

Applicable CCA notification and authorization policies and procedures apply. For more information on prior authorizations, please refer to the Prior Authorization Requirements in the plan specific Provider Manual.

REIMBURSEMENT REQUIREMENTS:

CCA covers 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.

Best Practice Guidelines:

- 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 requires 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.

REIMBURSEMENT REQUIREMENTS (cont.):

- 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. The comparable procedure should have a similar approach and similar anatomical site. It is necessary to provide the RVU's and/or charges for a similar procedure and provide an example of how the current procedure is more or less difficult and differentiates from the comparable procedure.
- When submitting supporting documentation highlight the portion of the report that identifies the test or procedure associated with the unlisted procedure code. The required information must be legible and clearly marked.

PROVIDER SUPPORTING DOCUMENTATION REQUIREMENTS:

CCA requires that providers submit supporting documentation when filing a claim with an unlisted procedure code. Appropriate 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.

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) and the plan specific Provider Manual: Section 6: Claims and Billing Procedures.

- 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.

DOCUMENTATION GUIDELINES BY PROCEDURE CODE: cms.gov

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

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. Please refer to CPT/HCPCS for complete and updated list of codes. 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, procedures, and claims editing logic. CCA has the right to conduct audits on any contracted 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.

RELATED SERVICE POLICIES:

Prior Authorization

REFERENCES:

Medicare Claims Processing Manual (cms.gov)

Payment Policies: Massachusetts / Rhode Island

Provider Manuals: Massachusetts / Rhode Island

Prior Authorization Forms: Massachusetts / Rhode Island

POLICY TIMELINE DETAILS

1. Effective: March 2019
2. Revision: August 2019 - Annual review and format revision
3. Revision: November 2021 - Revised Scope and Format
4. Revision: June 2022 - Updated claims mailing address, updated formatting
5. Revision: April 2023, add Medicare Premier – (PPO) MA** product, removed address under Supporting Documentation Requirements and added instructions to refer to section 6, of the Provider Manual, Claims and Billing Procedures