LifeWise Health Plan of Washington	**Payment Policy**

cmi_168163

Title	**Unlisted, Non-Specific and Miscellaneous Procedure Codes**		
Number	**CP.PP.392.v2.0**		
Last Approval Date	02/05/24	**Original Effective Date**	04/15/15
Cross Reference	• *Modifier 22 – Increased Procedural Services* • *National Drug Code (NDC) Billing Guidelines-Outpatient Facility Claims* • *National Drug Code (NDC) Billing Guidelines-Professional Claims* • *Durable Medical Equipment (DME)/Home Medical Equipment (HME)*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define the Plan's limitations on the use of "unlisted", "not otherwise specified" or "miscellaneous" CPT or HCPCS codes submitted on provider claims that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products. Medicare Advantage products are not subject to this policy.
Definitions	**Unlisted, Unspecified or Miscellaneous Codes**: An item, service or procedure that is represented by a non-specific code in either the Current Procedural Terminology (CPT) codebook or in the Healthcare Common Procedure Coding System (HCPCS) codebook. The actual code itself will state either "unlisted", "unspecified", "unclassified", "not otherwise specified (NOS) or classified (NOC)", "not elsewhere classified (NEC)" or "miscellaneous" in the code description.
Policy	As a result of advances in healthcare services and the technology used to deliver such healthcare services, physicians and other qualified healthcare care professionals may render procedures and services for which there is no specific CPT or HCPCS code available. Correct coding criteria indicates that to report such a procedure for which a specific CPT or HCPCS code is not found, the provider may use "unlisted codes", "unspecified codes", "not otherwise specified codes" or "miscellaneous codes" that are found in the various sections within each codebook. These codes usually end in XXX99 or XX999, are located at the ends of code sections in each of the above noted codebooks, or they are intermixed among the codes in the same section. These codes do not have specific language in the code description which identifies the components of the service. These non-specific codes therefore only provide a mechanism for reporting and tracking services and procedures for which a specific code is not yet established. These codes should only be used as a **last resort** if there is **NOT** a more specific CPT or HCPCS code available for use. When a **more specific** CPT or HCPCS code is available, the more specific CPT or HCPCS code should always be selected first. Failure to use a more specific CPT or HCPCS code, if one exists, will result in the code

being denied or sent back to the provider with the message to rebill with a more specific CPT or HCPCS code.

Supporting Documentation Requirement

Because non-specific CPT or HCPCS codes do not describe in detail what was performed or rendered as part of the procedure or service, the Plan **requires** supporting detailed documentation to be submitted in conjunction with the claim submission. Supporting documentation must describe in detail the specific service(s) rendered and identify what was performed as part of the service(s).

Such information may be contained in operative or procedure reports, imaging reports, laboratory or pathology reports, office notes, or a specific narrative on the claim depending on the procedure category for the non-specific unlisted/miscellaneous code(s). Clearly identify the portion of the report/documentation which identifies the test or procedure being billed with the unlisted procedure code.

Failure to provide supporting documentation that describes the specifics of the unlisted or miscellaneous code will result in the service being denied reimbursement.

If there is a “similar” or “like” code to the service that is being submitted with an unlisted or miscellaneous code(s), include the recommendation(s) along with the supporting documentation. Such information will assist in the review of the code.

Documentation that should be submitted with the submission of an unlisted or miscellaneous code includes the following examples for the various code categories:

CODE CATEGORY	Type of Documentation Required
UNCLASSIFIED/NOT OTHERWISE SPECIFIED/ MISCELLANEOUS DRUG HCPCS CODES: Including but not limited to J3490, J3590, J7599, J7699, J7799, J7999, J8498, J8499, J8999, J9999, Q0181	• NDC number with full description/name and strength of the drug, route of administration and service units • Diagnosis • Reason for use of the drug documented in provider notes • Any extenuating circumstances which may pertain to use of the drug • When requested, a copy of the original invoice for the drug • Number of times the service was provided
UNCLASSIFIED/NOT OTHERWISE SPECIFIED/ MISCELLANEOUS DME HCPCS CODES: Including but not limited to E1399, A9900, A9901, A9999, L8699, L9900, T1999, T5999	• Provide description of the service on the claim line • Diagnosis • Reason for use of the DME documented in provider notes • Any extenuating circumstances which may pertain to use of the DME • When requested, a copy of the original invoice or the MSRP which identifies the specific service being billed • Number of times the service was provided

		• Recommendation of a comparable code	
	ALL OTHER UNCLASSIFIED/NOT OTHERWISE SPECIFIED/ MISCELLANEOUS HCPCS CODES: Including but not limited to H0046, H0047, Q0181, Q4051, Q4100, Q5009, S5181, S8189, S9445, S9446, S9810, V5299, S9542	• Provide description of the service on the claim line • Diagnosis • Reason for use of the miscellaneous HCPCS code documented in provider notes. • Copy of original invoice which includes a full description of the unlisted service rendered • Any extenuating circumstances which may have complicated the service or procedure • Number of times the service was provided • If applicable, time, effort, and equipment necessary to provide the service (e.g., an estimation of the Relative Value Units (RVUs) for the procedure) • Recommendation of a comparable code	
	MEDICAL PROCEDURES: All unlisted codes within the CPT code range of 90281-99607 and/or By Report	• Provide description of the service on the claim line • Diagnosis • Reason for the procedure documented in provider notes • Office Notes and Reports which include a full description of the unlisted service rendered • Any extenuating circumstances which may have complicated the service or procedure • Number of times the service was provided • Whether the procedure was performed independent from other services performed at the same time or performed at the same surgical site or through the same surgical opening • If applicable, time, effort, and equipment necessary to provide the service (e.g., an estimation of the Relative Value Units (RVUs) for the procedure) • Recommendation of a comparable code	
	SURGICAL PROCEDURES: All unlisted codes within the CPT code range of 10021-69990 and/or By Report	• Provide description of the service on the claim line • Diagnosis • Reason for the procedure documented in provider notes • Operative or Procedure reports which include a full description of the unlisted service rendered • Any extenuating circumstances which may have complicated the service or procedure • Number of times the service was provided	

	• Whether the procedure was performed independent from other services performed at the same time or performed at the same surgical site or through the same surgical opening • If applicable, time, effort, and equipment necessary to provide the service (e.g., an estimation of the Relative Value Units (RVUs) for the procedure) • Recommendation of a comparable code
RADIOLOGY/IMAGING PROCEDURES: All unlisted codes within the CPT code range of 70010-79999 and/or By Report	• Provide description of the service on the claim line • Diagnosis • Reason for the procedure documented in provider notes • Imaging Reports which include a full description of the unlisted service rendered • Any extenuating circumstances which may have complicated the service or procedure • Number of times the service was provided • Recommendation of a comparable code
LABORATORY/PATHOLOGY PROCEDURES: All unlisted codes within the CPT code range of 80047-89398 and By Report	• Provide description of the service on the claim line • Diagnosis • Reason for use of the laboratory or pathology procedure documented in provider notes • Laboratory or Pathology Reports which include a full description of the unlisted service rendered • Any extenuating circumstances which may have complicated the service or procedure • Number of times the service was provided • Recommendation of a comparable code

Clinical Review of All Unlisted, Non-Specific and Miscellaneous Codes

All unlisted, non-specific, and miscellaneous CPT and HCPCS codes submitted on a claim, along with the supporting documentation described above will be subject to clinical review and review for coverage under the member's contract such as for cosmetic, investigational, or medical necessity at the time of claims submission.

The Plan does not review unlisted, non-specific, or miscellaneous CPT and HCPCS codes prior to service delivery; this subset of codes is not subject to prior authorization.

During the review of each submitted unlisted, non-specific, or miscellaneous code, the Plan will determine how that code will be priced (e.g., such as but not limited to basing on a comparable code, a comparable code with modifier 22- *Increased Procedural Services* added or on a percentage of charge) as part of the processing of the entire claim. Additional reimbursement may not be provided for method, special techniques, or equipment that is submitted with an unlisted procedure code.

	<u>Multiple Unlisted Codes</u> When two or more procedures are performed that are represented by the **<u>same non-specific unlisted/miscellaneous code,</u>** the unlisted/miscellaneous code should only be reported once with a single unit to identify the service since these codes do not identify a specific unit value or service. The supporting documentation should clearly identify which procedures were performed and the number of times the service was rendered. If there is a more specific CPT or HCPCS code that more accurately represents one or more of the multiple procedures represented by the same non-specific unlisted/ miscellaneous code, that CPT or HCPCS code should be billed instead of including the service under the same unlisted code. When performing two or more procedures that require the use of **<u>more than one non-specific unlisted/miscellaneous code for different anatomic locations,</u>** the unlisted codes can be reported for each different anatomic location, each with a single unit. Supporting documentation should clearly identify these different anatomic locations as well as clearly describe the specific procedure or services rendered.
Codes/Coding Guidelines	
Violations of Policy	Violations of this policy by any party that enters a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	None

References	• American Medical Association Current Procedural Terminology (AMA/CPT) codebook, Professional Edition
	• Healthcare Common Procedure Coding System (HCPCS) Level II Codes
	• Centers for Medicare and Medicaid Services (CMS) Publication 100-04-Medicare Claims Processing Manual
	    o Ch.4 – Part B Hospital, Section 180.3
	    o Ch. 12 – Physician/Non-Physician Practitioners, Section 30
	• National Correct Coding Initiative Policy Manual, Chapter 1
	• CMS National Physician Fee Schedule (NPFS)

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	02/05/24; 03/13/23; 04/08/22; 04/28/21; 04/16/21; 04/30/20; 05/24/19; 06/05/18; 03/29/18; 06/13/17; 12/12/16; 01/08/16; 01/11/15	
Version History	03/29/18;	Clarified what information Clinical Review will be looking for when they review an unlisted code

	06/05/18	• Added clarification regarding documentation to send to support any submission of unlisted codes. • Added two new sub-sections in the Policy statement to address unlisted DME and Drugs; • Added new section Codes/Coding Guidelines to the policy along with code descriptions referenced in the Policy and a table identifying documentation to supply for specific code categories noted
	05/24/19	Annual review; no changes
	04/30/20	Annual review; no changes
	04/16/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms.
	04/28/21	• Within the Policy statement, revised the section "Supporting Documentation Requirements" by inserting the Table of Codes from the "Codes/Coding Guidelines" section and providing more specific guidelines on what specific documentation is needed per code categories to support Clinical Review of the code(s). • Deleted sections "Unlisted Durable Medical Equipment and Miscellaneous Supplies and Services" and "Unlisted, Miscellaneous or Not Otherwise Classified/Specified Drugs" as they are included in the expanded Table of Codes. • Moved all the information in the "Codes/Coding Guidelines" section into the Table of Codes in the "Supporting Documentation Requirements" section. • The above changes become effective with claims processed on and after July 5, 2021
	04/08/22	• At the end of the Clinical Review of Unlisted Codes section of the Policy, added a note that additional reimbursement will not be made for surgical techniques, equipment, etc. submitted with an unlisted code. • Added the second paragraph under the Multiple Unlisted Codes section of the Policy to indicate that if a more specific CPT or HCPCE code more accurately represents one or more of the services rendered that the specific CPT or HCPCS code should be billed rather than an unlisted code.
	03/13/23	• In the Cross Reference section, added policy Modifier 22 - *Increased Procedural Services* • At the end of the Supporting Documentation Requirements section, revised the wording of the last paragraph • In each Code Category, indicated that a description of the service rendered is required on the claim line
	02/05/24	In the Table of Unlisted codes in the Policy section, added the following: o Added the bullet "Recommendation of a comparable code" to each section in the table o Added code examples to the section "ALL OTHER UNCLASSIFIED/NOT OTHERWISE SPECIFIED/ MISCELLANEOUS HCPCS CODES"