PAYMENT REIMBURSEMENT POLICY

Title: PRP-03 Unlisted CPT/HCPCS Codes

Category: Compliance

Related Benefit Coverage Policy: N/A

Effective Date: 01/01/2019

Physicians Health Plan
PHP Insurance Company
PHP Service Company

1.0 Guidelines:

This policy does not guarantee benefits. Benefits are determined and/or limited by an individual member Certificate of Coverage (COC). Reimbursement is not solely determined on this policy, Physicians Health Plan (PHP) reserves the right to apply coding edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. A prior authorization does not exempt adherence to the following billing requirements.

2.0 Description:

Correct coding requires that the code reported accurately represents the service provided. Unlisted procedure codes are to be used when no other CPT/HCPCS code exists to reflect the procedure or service the provider wants to submit for reimbursement. It may be a variation of a current service provided, but performed in a different surgical technique, or it may be a whole different type of treatment method that could be deemed experimental. It can also be defined as a component of other services performed (e.g., provider fails to document it as a separate and distinct service), and it may be denied if it is not supported within the documentation. Any service or procedure must be adequately documented in the medical record.

Unlisted codes provide the means of reporting and tracking services and procedures until a more specific code is established. As new and advanced approaches and techniques are under development, the unlisted codes are used for auditing purposes until these procedures become accepted in medical practice and are routinely performed by providers. Specific fee allowances and/or relative value units (RVUs) cannot be established for unlisted services or items. Fees for unlisted codes are assigned once the documentation has been reviewed.

Coding and Billing: Codes that are covered may be subject to medical benefit review and benefit limits.

- If the provider performs two or more procedures on the same anatomic location that require the use of the same unlisted code, the unlisted code should be reported only once to identify the services provided. If two or more procedures that require an unlisted code are performed on different anatomic locations, the unlisted code may be reported for each different anatomic location.
- Prior authorization may be required for procedures that could be considered unproven, experimental, investigational and/or cosmetic. The prior authorization request should be submitted on the designated form for this purpose which will allow the provider to describe the planned procedure in detail and the medical necessity. If the unlisted procedure is performed without prior authorization, a copy of the operative report should be submitted, along with information to support the decision-making process and the medical reasoning for performing the service.

3.0 Documentation Requirements:

When using an unlisted procedure code, provider should submit a clear narrative and supporting documentation to describe the service. Claims should be submitted with the following supporting documentation and details. Failure to submit supporting documentation may result in claim denial:

- A clear description of the nature, extent, and need for the procedure or service.
- The patient’s diagnosis and risk of complications and/or comorbidities.

- Whether the procedure was performed independent from other services provided, or if it was performed at the same surgical site or through the same surgical opening.
- Time, effort, and equipment necessary to provide the service.
- The number of times the service was provided.
- What was found during the surgery (e.g., the size and location of the lesions).
- For unlisted surgery codes, a reasonably comparable service code/procedure should be provided as well as value in comparable RVU and/or percentage of a reasonably comparable CPT.

The supporting documentation requirements for different types of unlisted procedures are as follows:

- Surgical procedures: Operative or procedure report providing the nature and extent of the patient condition and detailing the work involved in the procedure.
- Radiology/imaging procedures: imaging report.
- Lab and pathology procedures: Lab or pathology report.
- Medical procedures: office notes and reports.
- Medical supplies: invoice.
- Unlisted HCPCS codes: operative or procedure note.
- Clinical notes to support medical necessity.

Providers may also include published articles and clinical information supporting the efficacy of the procedure. All attachments should be sent with the original claim.

4.0 Verification of Compliance

Claims are subject to audit, prepayment and post payment, to validate compliance with the terms and conditions of this policy.

5.0 Terms & Definitions:

Healthcare Common Procedure Coding System (HCPCS) are billing codes developed by the Centers for Medicare and Medicaid Services (CMS). They are assigned to every task and service a medical practitioner may provide to a patient including medical, surgical and diagnostic services.

Current Procedural Terminology (CPT) are billing codes developed by the American Medical Association (AMA) that describe the range of services that can be billed for by a physician, hospital, or outpatient facility that provides medical services.

6.0 References, Citations & Resources:

1. Centers for Medicare and Medicaid Services, CMS Manual and other CMS publications.
2. American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and associated publications.

7.0 Revision History:

Original Effective Date: 01/01/2019

Last Approval Date: 11/20/2018

Next Revision Date: 11/20/2019

Revision Date	Reason for Revision
10/18	Policy created.

8.0 Document Evaluation Panel:

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