University of Michigan Health Plan

PAYMENT REIMBURSEMENT POLICY

Title: PRP-03 Unlisted CPT-HCPCS Codes

Category: UMHP_PAYMENT REIMBURSEMENT (PR)

Effective Date: 09/30/2024

1.0 Guidelines:

This policy applies to all network and non-network providers, including but not limited to percent of charge contract providers. This policy does not guarantee benefits or solely determine reimbursement. Benefits are determined and/or limited by an individual member's benefit coverage document (COC, SPD, etc.). The Health Plan reserves the right to apply clinical edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. The Health Plan may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS but are covered by the Health Plan to support covered benefits available through one of the Health Plan's products. Prior approval does not exempt adherence to the following billing requirements. The provider contract terms take precedence if there is a conflict between this policy and the provider contract.

2.0 Description:

Correct coding requires that the code reported accurately represents the service provided. Unlisted procedure codes are appropriate when no other CPT/HCPCS code exists to reflect the procedure or service the provider performed. Unlisted code selection may be appropriate when billing for a service performed via a surgical technique that is not defined in the current code description or for a new treatment that does not have an established CPT/HCPCS code. Any service or procedure billed with an unlisted code 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 reporting 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 as they can be applied to a variety of services. Pricing for unlisted codes is assigned once the documentation has been reviewed and the code audit approved.

3.0 Coding and Billing:

Codes that are covered may be subject to medical benefits 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, and documentation should indicate and support different locations.

- While unlisted codes do not require prior authorization, the services billed under an unlisted code may require prior authorization. Prior authorization may be required for procedures that could be considered unproven, experimental, investigational, and/or cosmetic. The prior authorization request must be submitted on the designated form with a complete description of the planned procedure. The request must include an indication of any devices, biomedical grafting, technique/approach, and/or other documentation to support medical necessity. A copy of the operative report must be submitted with the claim, along with information to support the decision-

making process, the medical rationale for performing the service, and the rationale for applying the unlisted code. If the unlisted procedure code is deemed to be an incorrect code selection or it is determined upon review of the documentation that the service billed is considered to be experimental/unproven, the service will be denied accordingly.

4.0 Documentation Requirements:

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

- A clear description of the procedure or service's nature, extent, and need.
- The patient's diagnosis and risk of complications and/or comorbidities.
- Whether the procedure was performed independently from other services provided or if it was performed at the same surgical site or through the same surgical opening.
- Time, effort, and equipment are 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)?
- A reasonably comparable service code/procedure RVU value and/or percentage of a reasonably comparable CPT should be provided for unlisted surgery codes.

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's condition and detailing the work involved.
- Radiology/imaging procedures: imaging report, order.
- Lab and pathology procedures: Lab or pathology report, order/requisition.
- Medical procedures: office notes and reports.
- Medical supplies: order with complete description of item and invoice.
- Unlisted HCPCS codes: operative or procedure note or order with complete description of item and invoice if DME item.
- Unlisted drug codes: NDC number, dose, and route of administration.

Clinical notes must support medical necessity. Providers may also include published articles and clinical information supporting the procedure's efficacy. All attachments should be sent with the original claim.

5.0 Verification of Compliance

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

6.0 Terms & Definitions:

Healthcare Common Procedure Coding Systems (HCPCS): 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): billing codes developed by the American Medical Association (AMA) that describe the range of services billed for by a physician, hospital, or outpatient facility providing medical services.

7.0 References, Citations, Resources & Associated Documents:

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.

8.0 Appendices:

None

9.0 Revision History:

Original Effective Date: 01/01/2019

Next Revision Date: 09/30/2025

Revision Date	Reason for Revision
10/18	Policy created.
8/19	Annual review; revisions to section 4.0.
10/20	Annual review; changes made to clarify policy language, approved by CCSC 12/1/20
9/21	Annual review; updated section 3.0, revisions to Guidelines section verbiage
12/22	Annual review
9/23	Annual review
7/24	Annual review