BlueCross BlueShield Minnesota

REIMBURSEMENT POLICY

Unlisted Procedure Code Policy

Active

Policy Number: General Coding – 005
Policy Title: Unlisted Procedure Code Policy
Section: General Coding
Effective Date: 12/02/14

Product: ☒Commercial ☒FEP ☒Medicare Advantage ☒Platinum Blue

Description

This policy addresses coverage and reimbursement for services that are submitted with an unlisted HCPCS (Level I, a.k.a., CPT, and Level II, alpha-numeric codes) code.

Definitions

Some services or procedures performed or supplied by practitioners might not have a specific HCPCS that adequately describes the procedure or service. When submitting claims for these services or procedures, unlisted codes may be used.

Unlisted codes are identified in part by one of the following terms in the HCPCS description:

- Not Otherwise Classified;
- Unlisted;
- Not Listed;
- Unspecified;
- Unclassified;
- Not Otherwise Specified;
- Non-Specified;
- Not Elsewhere Specified;
- NEC
- NOS

Policy Statement

Unlisted codes should only be used if no code exists to describe the procedure, service or supply.

Submit the unlisted code from the related HCPCS section and furnish the appropriate information based on the type of unlisted code. Select the most appropriate and specific unlisted code that reflects the procedure, service or supply rendered.

- For example, an oral drug is given (under the medical benefit) that does not have a specific code, J8499 (Prescription drug, oral, non-chemotherapeutic, NOS) would be more appropriate than submitting J3490 (unclassified drug).

At minimum, a complete narrative description of or identification of the service or item must be submitted or supplied. This information is entered in the electronic claim in the NTE segment:

- 837P: Loop 2400, Segment NTE
- 837I: Loop 2300, Segment NTE

If not included or attached, Blue Cross will send out the request for additional information and deny the claim simultaneously. However, once the additional information is received, the claim will be reprocessed.

Claims submitted with an unlisted procedure code will be denied if determined an appropriate procedure or service code that most closely approximates the service performed is available.

Claims billed with unlisted procedure codes and invalid or absent national drug codes (NDC), or without narrative information and/or supporting documentation will be denied.

Unlisted procedure codes (other than DME, orthotics and prosthetics) appended with a modifier may be denied.

Unlisted codes for DME, orthotics and prosthetics require the appropriate modifier to differentiate rental, purchase and repair or replacement of DME.

No additional reimbursement is provided for special techniques/equipment submitted with an unlisted procedure code.

Provider agrees to use unlisted procedure codes only when no code exists for the service being provided. Reimbursement for unlisted codes will be determined on one of the following methodologies:

- 85% of the Average Wholesale Price (AWP) for drug codes
- Percentage of Provider's Regular Billed Charge (55% of charge for Commercial and 35% of charge for Medicare)
- Invoice cost (reimburse drug cost only)
- Allowance of similar code (procedure/item)
- Wholesale Acquisition Cost (WAC) for gene therapy drugs– refer to *General Coding-074- Cellular and Gene Therapy Products Reimbursement Policy.*

Compounded drugs
Multiple service lines are necessary to report a compound drug. One NDC is allowed per line. Report the HCPCS code (J7999) as a separate line for each associated NDC, or full description/name and strength of the drug and dosage.

For injections/infusions that involve multiple NDCs, bill the initial line with the HCPCS code, units and NDC with modifier KP (first drug of a multiple drug unit dose formulation). Bill the second, and any subsequent line item(s) of the same HCPCS code with modifier KQ (second or subsequent drug of a multiple drug unit dose formulation). If billing the same HCPCS code on more than two lines, the KQ modifier and an additional modifier are needed on each subsequent line. Also refer to *General Coding – 031 Home Infusion Reimbursement Policy.*

Documentation Submission

Any service or procedure should be adequately documented in the medical record.

Because unlisted and unspecified procedure codes do not describe a specific procedure or service, it is necessary to submit supporting documentation when filing the claim or on request. Pertinent information should include:

- A clear description of the nature, extent, and need for the procedure or service.
- 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.
- 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, identify the portion of the report (such as underlining or highlighting the entry) that identifies the test or procedure associated with the unlisted procedure code. Required information must be legible and clearly marked. (Refer to the guideline below for documentation requirements.)

Procedure Code Category	Documentation Requirements
Surgical Procedures	Operative or procedure report
Radiology/imaging procedures	Imaging Report
Laboratory and pathology procedures	Laboratory or pathology report; Genetic test codes for Commercial products refer to *Lab Path Services – 008 Genetic/Molecular Test Coding Reimbursement Policy*
Medical Procedures and Behavioral Health Services	Office notes, chart notes and reports
Unclassified drug codes	Provide the National Drug Code (NDC) number or full description/name and strength of the drug and dosage
Unlisted DME HCPCS codes	Provide narrative on the claim, Manufacturers Suggested Retail Price (MSRP)

Coverage

Eligible services will be subject to the subscriber benefits, Blue Cross or Medicare fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider

Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	KP KQ
ICD-10 Diagnosis:	N/A
ICD-10 Procedure:	N/A
CPT/HCPCS:	Refer to Appendix
Revenue Codes:	N/A

Cross Reference

Cross Reference:

DME – 001 DME and Supplies
General Coding – 001 Modifier Reference Guide
General Coding – 012 Total Parental Nutrition Billing
General Coding – 025 Maternity
General Coding – 031 Home Infusion
General Coding – 037 Immunizations/Vaccines
General Coding – 038 Injections
General Coding – 054 Chemotherapy Administration
General Coding – 069 Ambulance Services
General Coding – 074 Cellular and Gene Therapy Products
Lab Path Services – 008 Genetic/Molecular Test Coding
Surgery/Interventional Procedure – 004 Modifier 22
Surgery/Interventional Procedure – 011 Insertion and Removal of Tympanic Ventilation Tubes

Resources

MDH Rule: MUCG V16.0 for the Implementation of the X12/005010X222A1 Health Care Claim: Professional (837)

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Policy History	
12/02/2014	Initial Committee Approval Date
04/06/2016	Annual Policy Review
08/30/2017	Annual Policy Review
01/27/2020	Annual Policy Review
01/04/2021	Annual Policy Review
06/29/2021	Annual Policy Review
12/28/2021	Policy update
03/22/2022	Policy update: reference added for genetic testing
04/26/2022	Code update: added A4100
09/27/2022	Policy update: added Compound Drug section

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Appendix

15999	17999	19499	20999	21089	21299	21499	21899	22899	22999
23929	24999	25999	26989	27299	27599	27899	28899	29799	29999
30999	31299	31599	31899	32999	33999	36299	37501	37799	38129
38589	38999	39499	39599	40799	40899	41599	41899	42299	42699
42999	43289	43499	43659	43999	44238	44799	44899	44979	45399
45499	45999	46999	47379	47399	47579	47999	48999	49329	49659
49999	50549	50949	51999	53899	54699	55559	55899	58578	58579
58679	58999	59897	59898	59899	60659	60699	64722	64999	66999
67299	67399	67599	67999	68399	68899	69399	69799	69949	69979
76496	76497	76498	76499	76999	77299	77399	77499	77799	78099
78199	78299	78399	78499	78599	78699	78799	78999	79999	80323
80338	80339	80340	80341	80342	80343	80344	80375	80376	80377
81099	81479	81599	83520	84591	84999	85999	86317	86486	86849
86999	87299	87449	87797	87798	87799	87899	87999	88099	88199
88299	88399	88749	89240	89398	90399	90749	90899	90999	91299
92499	92700	93799	93998	94799	95199	95999	96379	96549	96999
97039	97139	97799	99199	99429	99499	99600	0101T	1999	A0999
A4100	A4335	A4421	A4641	A4649	A4913	A5507	A6261	A6262	A6512
A6549	A9152	A9153	A9279	A9280	A9579	A9597	A9598	A9698	A9699
A9900	A9999	B9998	B9999	C1889	C2698	C2699	C9399	D0999	D1999
D2999	D3999	D4999	D5899	D5999	D6199	D6999	D7899	D7999	D8999
D9999	E0446	E0625	E0676	E0769	E0770	E1229	E1239	E1399	E1699
E2599	G0235	G9012	G9055	G9062	G9067	G9070	G9083	G9089	G9095
G9099	G9104	G9108	G9112	G9117	G9130	G9131	G9138	G9139	G9282
G9283	G9284	G9288	G9289	G9290	G9291	G9419	G9421	G9422	G9424
G9699	H0046	H0047	J0220	J0256	J1566	J1599	J1729	J3301	J3490
J3590	J3591	J7192	J7195	J7199	J7599	J7699	J7799	J7999	J8498
J8499	J8597	J8999	J9020	J9999	K0108	K0812	K0898	K0900	L0999
L1499	L2999	L3649	L3999	L5999	L7499	L8039	L8048	L8499	L8699
P9099	Q0181	Q0507	Q0508	Q0509	Q2039	Q4050	Q4051	Q4082	Q4100
Q5009	S0590	S2409	S4015	S5130	S5131	S5181	S5199	S5497	S8189
S8301	S9379	S9445	S9446	S9542	S9810	S9976	S9977	T1505	T1999
T2025	T2028	T2029	T2032	T2033	T5999	V2199	V2799	V5090	V5267
V5274	V5287	V5298	V5299						