UNLISTED/UNSPECIFIED CODES

Policy # 08

Implementation Date:	1/1/06
Revision Dates:	12/1/05, 8/27/13, 9/24/14

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare), and SelectHealth Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

Current coding guidelines require claims for services to be submitted using the "most specific" code applicable to the procedure/service. Many procedures, however, do not have a specific code that accurately reflects the service/procedure performed. In these cases, coding guidelines indicate an unlisted code should be used. In other situations, coding guidelines and regulations may also affect when an unlisted code should be used. (Example: the only code to describe a procedure is classified as an add-on code, but no primary procedure was done). Again, in this instance an unlisted code would be appropriate.

Due to the marked variability of the procedures/services used with an unlisted code, these codes are typically paid at a percentage of billed charges. In some situations, however, a specific procedure, which is billed using an unlisted code, may have enough information available to determine a fee schedule. In these situations, for the purposes of payment consistency, a permanent fee schedule is then established.

Commercial Plan Policy

SelectHealth requires documentation for all unlisted codes billed in order to make sure there is not a more appropriate code, and that the unlisted code is the only one that reflects the services being done based on the circumstances.

SelectHealth reimburses unlisted CPT and HCPCS Level II codes as well as some codes that do not have an established CMS Relative Value Unit at a percent of billed charges except in the following situations:

1. An RVU calculation can be found for the determination of a specific fee,

2. Adequate local, regional, or national claims experiences exist, which allows the determination of a specific fee,

3. The procedure for which the code is used is so similar to another procedure which has a listed CPT, HCPCS Level II code, or other accepted code and fee that an equitable fee can be established (i.e., unlisted laparoscopic procedure vs. equivalent open procedure),

4. Adequate local, regional, or national pricing for specific procedures exist, which allows the determination of a base value to derive a specific fee.

SelectHealth Advantage (Medicare/CMS)

SelectHealth Advantage **will follow Commercial Policy with the addition** that all unlisted codes require a prior authorization.

SelectHealth Community Care (Medicaid)

SelectHealth Community Care **will follow Commercial Policy with the addition** that all unlisted codes require a prior authorization.

Sources

1. *Current Procedural Terminology (CPT®)*, (2014) – American Medical Association.
2. ICD-9-CM Coding Guidelines. (2013, January 1). Retrieved July 8, 2014, from https://www.encoderpro.com/epro/physicianDoc/pdf/i9v1/i9_guidelines.pdf
3. NCCI. (2014, January 1). General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare Services Chapter 1. Retrieved September 17, 2014.
4. CPT® Assistant, June 2014, p. 14, *Frequently Asked Questions*.

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

SelectHealth makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. SelectHealth updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or SelectHealth members. Claims will be reviewed based on current policy language at time of review.

Members may contact Customer Service at the phone number listed on their member ID Card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call SelectHealth Provider Relations at 801-442-3692.

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