Premier Health Insuring Corporation
POLICY AND PROCEDURE MANUAL

Policy Number: MP.056.PC
Last Review Date: 11/12/2015
Effective Date: 01/01/2016
Renewal Date: 01/01/2017

MP.056.PC - Management of Unlisted/Non-Specific HCPCS/CPT Codes

This policy applies to the following line(s) of business:

- ✓ Premier Health Insuring Corporation MA – DSNP

Premier Health Insuring Corporation considers Management of Unlisted/Non-Specific HCPCS/CPT Codes as outlined below:

1. All claims submitted with unlisted codes will be held for further review.
2. When using an unlisted CPT code, the following must be included, legible, and clearly highlighted:
   - A narrative description or Operative Note describing the service represented by this code(s) and how the charges were derived
   - Adequate definition or description of the nature, extent and need for the procedure or service
   - Laboratory, Radiology or other diagnostic procedure reports that identify the test or procedure associated with the unlisted code.

Limitations

1. Claims using unlisted codes with no remarks or attachments as described above will be returned to the provider.
2. If remarks or attachments submitted do not clearly identify the test or procedure related to the code, the claim will be returned to the provider.
3. Separate reporting of any unlisted procedure code indicates a separate procedure was performed, independent of other procedures or services on the claim. Unbundling of any procedure or service by use of an unlisted HCPCS code is not appropriate and may be considered fraudulent.
4. Claims with unlisted/non-specific codes used for procedures deemed to be experimental and investigational will be denied.
5. Unlisted/Non-specific codes used for the following outpatient services are **not covered**:
   - Charges for Lab tests, EKG's and X-rays performed "stat".
   - Charges for use of portable equipment.
   - Oxygen therapy billed with one day surgery, clinic or emergency services.
   - Routine handling charges to refer a specimen from one laboratory to another.
   - Tests performed as part of a research grant or study.

Background

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Current Procedure Terminology (CPT) codes are used to describe medical procedures and physician services. The American Medical Association (AMA) maintains and distributes CPT codes.

Health Care Common Procedure Coding System (HCPCS) code set represents items, supplies and non-physician services not covered by the CPT codes. The Centers for Medicare and Medicaid Services (CMS) establishes and maintains the HCPCS codes.

The intent of establishing these code sets was to enable providers to use the most specific and appropriate code when submitting claims for reimbursement of services rendered to members.

Occasionally, a HCPCS code may not be available for a surgical procedure or service if it is rarely used, unusual or new. Providers then would use “unlisted” generic codes for any such procedure or service.

Codes:

CPT Codes / HCPCS Codes / ICD-10 Codes	
Code	Description
The following codes do **not** require medical notes, however all current requirements, if any, remain in place for these codes**:**	
90999	Unlisted dialysis procedure, inpatient and outpatient
E1399	Durable medical equipment, miscellaneous
K0108	Wheelchair component or accessory, NOS
J3490	Unclassified drugs
J3590	Unclassified biologics
J8999	Prescription drug, oral, chemotherapeutic, NOS
J9999	NOC, antineoplastic drugs

References

1. American Medical Association (AMA). CPT Process: How a Code Becomes a Code. http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/cpt-process-faq/code-becomes-cpt.page

2. Centers for Medicare and Medicaid Services (CMS). Code Sets. Last modified 09/26/2014. https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/TransactionCodeSetsStands/CodeSets.html
3. Centers for Medicare and Medicaid Services (CMS). Medicare Learning Network (MLN) Matters No. MM6320- Revised: January 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS), Effective 1/1/2009; Updated: 12/7/2012. http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6320.pdf
4. Centers for Medicare and Medicaid Services (CMS). Medicare Learning Network (MLN) Matters No. SE1138 - Revised. Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims. Revised: 1/13/2012 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1138.pdf

Disclaimer:
Premier Health Insuring Corporation medical payment and prior authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. The policies constitute only the reimbursement and coverage guidelines of Premier Health Insuring Corporation and its affiliated managed care entities. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies.

Premier Health Insuring Corporation reserves the right to review and update the medical payment and prior authorization guidelines in its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.