EFFECTIVE DATE: 04|01|2003
POLICY LAST REVIEWED: 12|20|2023

OVERVIEW

It is recognized that some medical services or procedures performed by physicians and facilities do not have a code assigned to them. Therefore, a number of unlisted procedure codes have been designated for reporting these unlisted procedures. Unlisted CPT codes specify "unlisted procedure," while HCPCS codes use the terms "miscellaneous," "not otherwise specified," "not otherwise classified," and "unclassified" in addition to "unlisted."

MEDICAL CRITERIA

Not applicable.

PRIOR AUTHORIZATION

Not Applicable

POLICY STATEMENT

Medicare Advantage Plans and Commercial Products
Professional Claims billed on a HCFA-1500 Form
Unlisted Surgical Procedures
The CPT and HCPCS manuals provide unlisted procedure codes for healthcare providers to report services for which there is no specific code descriptor available. All claims filed with an unlisted code will pend for review.

Unlisted procedure codes should not be used unless there is not an established code which adequately describes the procedure. An "Unlisted Procedure Claim" form, (as attached below), must be completed and the required supporting documentation provided.

Unlisted Form for Procedures

To ensure correct claim review, all claims filed with an unlisted CPT or HCPCS code **must be** submitted with the completed Unlisted Claim form and supporting documentation i.e. medical records. Claims submitted without the completed Unlisted Procedure form will deny for documentation.

Pertinent information should include a clear definition, description or name of the procedure performed and why it is not appropriate to use a more specific code. Unlisted surgical procedures require a copy of the operative note; unlisted radiologic and laboratory procedures require a copy of the report. When multiple procedures are performed, the services that are being reported with the unlisted procedure must be clearly differentiated from those that are reported separately. It is not appropriate to use an unlisted procedure code due to a procedure being unusually complex or a reduced service.

Note: When a surgical CPT code exists for an "open" procedure only and the procedure was performed laparoscopically, the CPT code will be approved with a 20% reduction of the allowed amount for the service.

Unlisted drug codes
Claims for unlisted and non-specific drug codes require submission of the 11-digit National Drug Code (NDC) in the correct format. The Unlisted Drug Code List identifies all codes that require the submission of an NDC. If the NDC is not submitted, the claim will not be processed and will be returned for correction.

Unlisted durable medical equipment codes
Claims for unlisted and non-specific durable medical equipment items require submission of the invoice for the item, the appropriate unlisted HCPCS code and the completed unlisted form below.

Unlisted Form for DME

COVERAGE
Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable benefits/coverage for the service.

CODING
Not Applicable

RELATED POLICIES
Coding and Payment Guidelines/Modifiers
Durable Medical Equipment
Preauthorization via Web Based Tool for Durable Medical Equipment
Preauthorization via Web Based Tool for Procedures
Genetic Testing Services
Claim Filing Requirements for Drugs

PUBLISHED
Provider Update, February 2024
Provider Update, February 2023
Provider Update, October 2021
Provider Update, March 2020
Provider Update, April 2018
Provider Update, April 2017
Provider Update, July 2016

REFERENCES:
None

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.