

# Unlisted and Unspecified Procedure Codes

## Overview<sup>1</sup>

Some services or procedures performed by providers might not have specific Current Procedure Codes (CPT) or HCPCS codes. When submitting claims for these services or procedures that are not otherwise specified, unlisted codes are designated. Unlisted codes provide the means of reporting and tracking services and procedures until a more specific code is established.

According to the Current Procedural Terminology Instructions for use of the CPT Codebook, select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code. Any service or procedure must be adequately documented in the medical record.

## Supporting Documentation Requirements

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

- A clear description of the nature, extent, and need for the procedure or service.
- Comparable CPT/HCPCS procedure code, when possible.
- 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, designate the portion of the report 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	Example	Documentation Requirements
Surgical procedures: all unlisted codes within the range of 10021–69990	CPT 19499 — unlisted procedure, breast	Operative or procedure report
Radiology/imaging procedures: all unlisted codes within the range of 70010–79999	CPT 76496 — unlisted fluoroscopic procedure (e.g., diagnostic, interventional)	Imaging report
Laboratory and pathology procedures: all unlisted codes within the range of 80047–89398	<ul style="list-style-type: none"> <li>• CPT 84999 — unlisted chemistry procedure</li> <li>• CPT 89240 — unlisted miscellaneous pathology test</li> <li>• CPT 81479 — unlisted molecular pathology procedure</li> </ul>	Laboratory or pathology report
Medical procedures: all unlisted codes within the range of 90281–99607	CPT 92499 — unlisted ophthalmological service or procedure	Office notes and reports
Unlisted HCPCS codes	G6021-Unlisted procedure, small intestine	Operative or procedure report

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PAYMENT POLICIES

Unlisted and Unspecified Procedure Codes (cont.)

Procedure Code Category	Example	Documentation Requirements
Unclassified drug codes	<ul style="list-style-type: none"> <li>• J3490 — Unlisted drugs</li> <li>• J7999 — Compounded drug, not otherwise classified</li> <li>• A4641 — Radiopharmaceutical, diagnostic, not otherwise classified</li> </ul>	<p><b>Paper claim submitters</b></p> <ul style="list-style-type: none"> <li>• CMS-1500 Form: Report the unlisted J code in 24D and units in 24G. To report NDC: In shade area of the line-item field (24A-24G), enter the N4 qualifier immediately followed by 11 digit NDC number — <i>left justified, enter 1 space then qualifier for dispensing unit of measure followed by quantity.</i></li> <li>• UB-04 Form: Report the unlisted J code in Form Locator 44 and units in Form Locator 46. To report NDC: In form Locator 43 enter the N4 qualifier immediately followed by 11 digit NDC number without hyphens — <i>left justified. NDC will be followed immediately by the qualifier for dispensing unit measure followed by quantity.</i></li> </ul> <p><b>Electronic claim submitters</b></p> <ul style="list-style-type: none"> <li>• 837P — Report the unlisted J code in the SV101-2, loop 2400 and the NDC Number with N4 qualifier in the LIN segment, loop 2410. When reporting NDC the CTP segment is required — both CTP04 (NDC count) and CTP05 (unit of measure).</li> <li>837I — Report the unlisted J code in the SV202-2, loop 2400 and the NDC Number with N4 qualifier in the LIN segment, loop 2410. When reporting NDC in LIN segment the CTP segment is required — both CTP04 (NDC count) and CTP05 (unit of measure).</li> </ul>
Unlisted DME HCPCS codes	Provide narrative on the claim	Provide narrative on the claim

**Provider Billing Guidelines and Documentation**

- Claims submitted with unlisted procedure codes and without supporting documentation will be denied.
- Please submit paper claims for unlisted procedure codes with the exception of unlisted drugs (see Procedure Code Category in coding table above). Electronic claims for unlisted procedure codes may be denied, as attachments are not accepted electronically at this time.
- Claims submitted with an unlisted procedure code will be denied if determined that a more appropriate procedure or service code that most closely approximates the service performed is available.
- No additional reimbursement is provided for special techniques/equipment submitted with an unlisted procedure code.
- Reporting an unlisted procedure code for the use of robotic or computer assisted surgical navigation does not increase the reimbursement for performing the service.
- Unlisted procedure codes appended with a modifier may be denied. (Exception: Unlisted codes for DME, orthotics and prosthetics require appropriate NU, RR or MS modifier.)
- When performing two or more procedures that require the use of the same unlisted CPT code, the unlisted code should only be reported once to identify the services provided (excludes unlisted HCPCS codes; for example, DME/ unlisted drugs).

**Medical Record Documentation and Physician Queries**

Harvard Pilgrim will not accept retrospectively amended medical records or physician queries beyond 30 days from the service date. Harvard Pilgrim considers medical record documentation and/or physician queries upon review as the official record to support services provided for the basis of coverage or reimbursement determination. Clinical documentation or physician queries amended over 30 days from the service will not be accepted to defend reimbursement, increase reimbursement, or consideration of a previously denied claim.

**PUBLICATION HISTORY**

10/31/04	original documentation
01/31/08	annual review; clarified modifier billing statements
07/31/08	added Medical Record Documentation information
01/31/09	annual review; minor edits to table

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## PAYMENT POLICIES

### Unlisted and Unspecified Procedure Codes *(cont.)*

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11/15/09	annual review; clarified billing for unlisted service and existing policy on non-reimbursement of special techniques/equipment; added unlisted codes 89240, A4641 to example
12/15/11	annual review; no changes
01/01/12	removed First Seniority Freedom information from header
11/15/12	annual review; minor edits
12/15/13	annual review; no changes, administrative edits only
01/15/14	administrative edits
01/15/15	annual review; clarified claim submission and reimbursement guidelines for paper and electronic claims; administrative edits; annual coding update; added HCPCS code G6021
01/15/16	annual review; added unlisted CPT code 81479 to Supporting Documentation Requirements section; updated EDI billing guidelines; administrative edits; annual coding update; added HCPCS code J7999
01/15/17	annual review; no changes
12/15/17	annual review; updated Provider Billing Guidelines and Documentation section to clarify unlisted drugs electronic submission
01/02/19	annual review; no changes
01/02/20	annual review; clarified reimbursement terms for use of robotic or computer assisted surgical navigation devices
01/04/21	annual review; administrative changes; added "Comparable CPT/HCPCS procedure code when possible" to Supporting Documentation Requirements

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<sup>1</sup>This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.