Priority Health	BILLING POLICY No. 069
UNLISTED CODES	
Date of origin: Dec. 30, 2024	**Review dates: 2/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

An unlisted CPT or HCPC code is a code used when there isn't a specific code to accurately describe a procedure, service or item.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Coding specifics

Professional claims

- Medical records must be submitted for claims that have an unlisted code.
- If it's determined that a more appropriate procedure code is available, the claim line with the unlisted code will be denied.
- Additional reimbursement may not be provided for special techniques / equipment submitted with an unlisted procedure code.
- 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).
- Bundling rules apply to services billed with an unlisted code.

Facility claims

- Identify the unlisted procedure by including a note describing what item or service was supplied. Use the note segment: NTE - Third-party Organization Notes in the electronic claim, or the FL80 remark section of the paper UB-04.
- Provide a comparable CPT (when possible). This provides us with detailed information regarding comparable services.

Unlisted drugs

- Make sure to provide the name of the drug, NDC and the dosage.
- An invoice is needed when submitting an unlisted code for a compound drug.

DME, P&O or other supplies

Be sure to include the following on the claim:

- Name of the item
- Manufacturer of the item

- Specific documentation on why you're using an unlisted HCPCS code.

Place of service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements
The medical record must clearly define the procedure, service or item that is billed. This can be done by underlining or adding an asterisk by the portion of the medical record. In addition to flagging the medical record, you must fill out an Unlisted code explanation form.

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Get more information on modifier use in our Provider Manual.

RESOURCES

- CPT 2025

DISCLAIMER
Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim

payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added “Disclaimer” section