JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.013
		Effective Date	12/30/2023
		Approval Date	09/27/2023
	Subject **Unlisted Codes, Professional**	*Supersedes Date*	06/01/2020
		Original Date	12/30/2023
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This document applies to the following Participating Organizations:

Advantage MD	EHP	Priority Partners	US Family Health Plan

Keywords: CPT, HCPCS, RVU, Unlisted Codes

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I. ABOUT OUR REIMBURSEMENT POLICIES

ABOUT OUR REIMBURSEMENT POLICIES:

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual". The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all providers (e.g., practitioners, hospitals, suppliers, non-physician providers, etc.) eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim

- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

To provide basic billing and reimbursement guidance for when an unlisted CPT/HCPC item, service or procedure code is reported on a CMS-1500 claim form or its electronic equivalent, from participating and non-participating physicians, providers and suppliers.

III. POLICY STATEMENT

JHHP requires that a provider submit all pertinent information (including, but not limited to) a definition or description of the nature, applicable modifier, extent and need for the item, procedure or service, as well as the provider's time, effort, and equipment necessary to provide the service. Providers are responsible to obtain a prior authorization/reauthorization before an unlisted item, procedure or service is rendered to a JHHP member. Additionally, providers are responsible for determining if a CPT/HCPCS code requires preauthorization. Each line of business possesses its own unique contract and guidelines which, for benefit and payment purposes, should be consulted first to know what benefits are available for coverage. Due to changes in regulatory, CMS and State guidance, and provider contracts, additional codes may apply.

IV. BILLING GUIDELINES AND PAYMENT METHODOLOGY

An unlisted CPT/HCPCS code represents an item, service, or procedure for which there is no specific code. The CPT manual lists a number of unlisted items, service or procedure codes, which can be found at the end of a section or subsection. Alternatively, a summary list of the unlisted CPT codes can be found in the Guidelines section for each chapter of the CPT code book. Typically, the long descriptors for these codes start with the term "Unlisted" and the last two digits of the codes often end in "99."

A. Unlisted codes should be reported only when no other specific CPT/HCPCS codes adequately describe the item, procedure or service.
B. Unlisted CPT/HCPCS codes unit value must be reported as one (1).
C. Submit the appropriate modifier(s) to the claim line, if applicable.
D. All CPT and HCPCS codes classified as "Unlisted" require prior authorization.
E. JHHP allows reimbursement for valid unlisted codes with prior authorization supported by the appropriate documentation. Claims submitted with an unlisted code, without a prior authorization, may be denied.
F. Claims submitted with unlisted procedure codes and without supporting documentation will be denied.
G. In certain circumstances, those claims submitted with an unlisted CPT/HCPCS code may be reviewed to ensure that no existing code adequately describes the item, procedure or service reported.
    i. If JHHP determines that an unlisted code submitted can be described by a more appropriate CPT/HCPC code, the claims will denied.
H. No additional reimbursement is provided for special techniques/equipment submitted with an unlisted procedure code.
I. Reporting an unlisted procedure code for the use of robotic or computer assisted surgical navigation does not increase the reimbursement for performing the service.
J. The appropriate determination of the payment of the unlisted drug or biological will be determined by the Plan, not the number of units billed.
K. Refer to JHHP's Reimbursement Policies for additional billing guidance.

V. DOCUMENTATION GUIDELINES

In alignment with CMS, providers should submit adequate yet thorough, documentation to ensure that claims are supported as billed. It is the provider who is ultimately responsible for requesting the prior authorization(s) and to submit the supporting documentation, within the established timelines. Failure to do so can result in the claims being denied or a delay in processing the claim. Documentation submitted is to include, but not limited to:

1. Medical records (i.e. imaging, lab, pathology, operative or office reports, etc.).
2. Accurate and complete definition or description of the item, procedure, or service, reported for reimbursement.
3. Number of times the service was provided.
4. When reporting the same unlisted code more than once, the unlisted code may require the use of a modifier. Documentation should support and detail the additional unlisted code(s), when the claims is submitted for reimbursement.
5. JHHP will not accept retrospectively amended medical records from providers to defend reimbursement, increase reimbursement, or reconsideration of a previously denied claims.
6. Extent and need for the item, procedure or service.
7. 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.
8. Any extenuating circumstances which supports the need to bill an unlisted code.
9. The provider's time, effort, and equipment necessary to provide the service.
10. For Durable Medical Equipment, prosthetic, orthotic or supply (DMEPOS), submit the manufacturer's invoice for unlisted item or code and product number (UPN), along with a narrative/description included on claim, including the name of the item.
11. For unlisted drug codes, include (but not limited to):
    - Manufacturer invoice with the complete drug name or description included on claim
    - National Drug Code (NDC) number
    - NDC unit to reflect the quantity of drug product administered
    - Dosage for unlisted or miscellaneous drug or biological
    - NDC product package size unit of measure (e.g., UN, ML, GR, F2)
    - NDC qualifier
    - Applicable modifier, if appropriate
    - Refer to the FDA National Drug Code Directory for additional guidance.
12. The provider may provide a comparable CPT/HCPCS code(s), value in comparable RVU, and/or a percentage of a reasonably comparable charges that would reflect item, procedures or services rendered as a suggestion for pricing the unlisted code reported. It is up to JHHP to determine if this information will be taken into consideration for pricing.
13. Required information must be legible and clearly marked.

VI. EXCLUSIONS & EXCEPTIONS

1. **PPMCO:** Please consult the authoritative guidance found in the Maryland Medicaid Professional Services Provider Manual for specific requirements for unlisted codes billing and reimbursement methodologies.

2. **USFHP**: Please consult the authoritative guidance found in the TRICARE Manuals to obtain specific information on policy, benefits, and coverage, as well as the TRICARE No Government Pay Procedure Code List (NGPCL).

VII. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition
837I	The 837I (Institutional) is the standard format used by institutional providers to transmit health care claims electronically.
CMS-1500	The CMS-1500 form is the standard claim form used by a non-institutional provider or supplier to bill carriers and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), and in some cases, ambulance providers, when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims.
National Uniform Claims Committee (NUCC)	The National Uniform Claims Committee (NUCC) makes the CMS-1500 manual available through its website. This manual contains the updated specifications for the data elements and codes included on the CMS-1500 and used in the 837I transaction standard.
Unlisted Codes	Unlisted codes are identified in part by one of the following terms in the CPT/HCPCS code description: • Not Elsewhere Classified (NEC) • Not Elsewhere Specified (NES) • Not Otherwise Classified (NOC) • Not Otherwise Specified (NOS) • Non-Specified • Not Listed • Unclassified • Unlisted • Unspecified

VIII. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Claims Processing Manual Chapter 12
- National Uniform Billing Committee (NUBC)
- NCCI Policy for Medicare & Medicaid Services
- TRICARE Reimbursement Manual

IX. REVISION HISTORY

Date	Review or Revision	Reason for Modification	Approved By:

JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.013
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9/27/2023	Revision	Updated policy language and references	Reimbursement Policy Committee (RPC)