CLINICAL PAYMENT AND CODING POLICY

If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Unlisted/Not Otherwise Classified (NOC) Coding Policy

Policy Number: CPCP035

Version 3.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: September 22, 2021

Plan Effective Date: January 8, 2022 (Blue Cross and Blue Shield of Texas Only)

Description

When billing for a drug, supply, service or procedure, providers should select the CPT or HCPCS code that accurately describes the administered drug(s), service(s) or procedure(s) performed. If and only if no code exists, providers should report the drug, service or procedure code using the appropriate unlisted procedure code. Unlisted procedure codes are used when the overall procedure and outcome of the procedure are not adequately described by an existing procedure code. Such codes are used as a last resort and only when there is not a more appropriate procedure code. **When submitting an unlisted procedure code, supporting documentation must be submitted.**

The Plan reserves the right to request supporting documentation. Claims that do not adhere to coding and billing guidelines may result in a denial or reassigned payment rate. For example, if a claim is submitted with an unlisted code and a more appropriate procedure or service code is available the claim may be denied and a corrected claim with the appropriate code should be submitted. The Plan reviews claims on a case-by-case basis.

Health care providers (facilities, physicians and other qualified health care professionals) are expected to exercise independent medical judgement in providing care to members. This policy is not intended to impact care decisions or medical practice.

This policy applies to In-Network and Out-of-Network professional providers and facilities.

For purposes of this policy, an unlisted code can be identified by the following terms:

- Non-Specified
- Not Listed
- Not Elsewhere Specified (NEC)
- Not Otherwise Classified (NOC)
- Not Otherwise Specified (NOS)
- Unclassified
- Unlisted
- Unspecified

Reimbursement Information:

The Plan recognizes there are instances when an unlisted code may be eligible for reimbursement because a more specific code does not exist that accurately reflects the drug, supply, service, or procedure rendered. Unlisted codes that are submitted for reimbursement must be accompanied with supporting documentation in order for the Plan to determine whether services that were rendered meet the member's benefit coverage and are aligned with medical necessity guidelines. Supporting documentation includes, but is not limited to, the following:

- An accurate and complete description of the drug, service or procedure;
- All related information to determine the medical necessity for the drug, service or procedure;
- An invoice for unlisted DME or supply codes;
- NDC qualifier, number of NDC units and NDC unit of measure;
- Any information pertaining to whether the drug, service or procedure was provided separately from any other service or procedure.

The following unlisted procedure code types require specific documentation:

Unlisted Code Type	Documentation Criteria	Examples

Anesthesia Unlisted Service or Procedure	• Special report
	  ○ Adequate definition or description of the nature, extent and need for the procedure
	  ○ Time
	  ○ Effort
	  ○ Equipment necessary to provide service
		• CPT code 01999: Unlisted Anesth Procedure

Imaging/Radiology Procedures	• Diagnosis; • Imaging report (including test(s) and results of test)	• CPT code 76999: Echo examination procedure
Lab/Pathology Procedures	• Lab/pathology report (Note: Item 19 of the CMS- 1500 claim form must include the specific name of the lab test(s) and/or a short descriptor of the test(s).)	• CPT code 86849: Immunology procedure
Medical Procedures	• Office notes and any reports	• CPT code 96999: Dermatological procedure
Surgical Procedures	• Description of the extent and need for the procedure; • Operative or procedure reports, office notes; • Explanation as to why a standard coded CPT procedure is not appropriate; • Comparable CPT/HCPCS service code(s), value in comparable RVU and/or a percentage of a reasonably comparable CPT/HCPCS that would reflect services performed.	CPT codes • 48999: Pancreas surgery procedure • 95999: Neurological procedure
Unlisted DME HCPCS Codes	• Narrative/description included on claim, including the name of the item, manufacturer and product number (UPN); • If applicable a copy of the invoice.	• HCPCS code A9999: Miscellaneous DME supply or accessory, not otherwise specified

Unclassified/Unlisted Drug Codes	• Necessary information needed to process valid unlisted drug codes: ○ NDC qualifier, N4; ○ NDC billing number (11-digit billing format, with no spaces, no hyphens and no special characters). If the NDC on the package label is less than 11 digits, a leading zero must be added to the appropriate segment to create a 5-4-2 configuration; ○ NDC product package size unit of measure (e.g., UN, ML, GR, F2); ○ The NDC must be submitted along with the accurate HCPCS/CPT code(s) and the number of HCPCS/CPT units; ○ NDC unit to reflect the quantity of drug product administered. The plan will accept up to three decimals in the NDC units (quantity of number of units) field. Failure to include appropriate decimals in the NDC units' field may lead to incorrect payments subject to review or audit; ○ The NDC must be active for the date of service. **Note:** Providers would list one unit of service in the 2400/SVI -04 data element or in item 24G of the CMS 1500 form or in field 46 of the UB-04. Do not quantity bill CPT/HCPCS units for NOC drugs or biologicals even if multiple units are provided unless otherwise directed for specific products. The appropriate determination of the payment of the NOC drug and biological will be determined by the Plan, not the number of units billed.	HCPCS codes • J3490: Unclassified drugs • J3590: Unclassified biologicals • J7999: Compounded drug, not otherwise classified • J9999: Not otherwise classified, antineoplastic drugs • C9399: Unclassified drugs or biologicals
Unlisted Services for E/M	• Special report ○ Adequate definition or description of the nature, extent and need for the procedure ○ Time ○ Effort ○ Equipment necessary to provide service Note: additional items may be provided such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems and follow-up care.	• CPT code 99499: Unlisted E&M Service

Some services or procedures require prior authorization. Providers are urged to refer to the Plan's prior authorization list and/or other Plan documents.

Billing Guidelines

- Unlisted CPT/HCPCS codes unit value must be reported as one (1).
- If an unlisted code is submitted, providers should use the most specific unlisted code that is available. For example, CPT code 76999 (Echo examination procedure) would not be appropriate for an unlisted dermatological procedure that would be more appropriately billed under CPT code 96999.
- CMS-1500 claim forms or electronic equivalent, must include the description of the unlisted code in Item 19. If the description does not fit, an attachment should be submitted with the claim.
- CMS-1500 claim forms or electronic equivalent, must include the procedure code without a description in Item 24D. If an unlisted procedure code is included in Item 24D a narrative description should be included in Item 19.
- For institutional outpatient coding, when using an unlisted CPT/HCPCS drug code, provide the name of the drug or medication (e.g., NDC number) in Box 43 of the UB-04 form.

References:

Medicare Claims Processing Manual. Chapter 26-Completeing and Processing Form CMS-1500 Data Set https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26pdf.pdf

National Drug Code (NDC) Billing Guidelines – BCBSTX provider website

Policy Update History:

09/22/2021	New policy