Unlisted Procedures and Services Payment Policy

Policy

The Plan reimburses for unlisted procedures and services that are prior authorized. This policy applies to the payment of unlisted procedures and services rendered in all settings. The purpose of this policy is to ensure the appropriate use and reimbursement of unlisted procedure codes.

The Plan expects that the use of unlisted codes is limited to situations where there is truly no listed code or combination of codes that adequately describes the service provided.

Definitions

An unlisted procedure code provides the means of reporting procedures or services that do not have an established CPT/HCPCS code. Unlisted codes do not include descriptor language that specifies the components of a particular service. Unlisted codes provide the means of reporting and tracking services and procedures until a more specific code is established.

Reimbursement

The Plan reimburses medically necessary and prior authorized unlisted procedures and services.

Since unlisted procedure codes do not describe a specific procedure or service, prior authorization requests and claims must be submitted with supporting documentation and are subject to Medical Director review. Similar codes to the unlisted code will be identified to determine reimbursement. Supporting documentation should include the following:

- A cover letter outlining the need for an unlisted code and how the charges are derived;
- Operative report or office note which accurately describes the unlisted surgical code used;
- Adequate definition or description of the nature, extent, and need for the procedure or service;
- Time, effort, and equipment necessary to perform the procedure or service;
- Any complicating circumstances (such as complexity of symptoms and concurrent problems).

Referral/notification/prior authorization requirements

Prior authorization is required for unlisted procedures for covered services.

Billing/coding guidelines

Unlisted codes require review of procedural documentation. Claims must be submitted with this supporting documentation. Claims submitted without supporting documentation will be denied.

Do not append modifiers to unlisted procedure or service codes.

Unit value should always be one (1).

Place of service

This policy applies to facility and professional services rendered in all settings.

Policy history

Origination date:	09/14/05
Previous revision date(s):	01/01/06 05/01/09 – Updated billing/coding guidelines section of the facility policy to more accurately explain the process for reviewing supporting documentation.

	01/01/2010 – Combined facility and professional policies, edited language to apply to all unlisted codes – not just unlisted surgical codes, and updated language in the reimbursement section to describe how reimbursement is determined. 09/01/2013 - Clarified discussion of the review process. 01/01/2016 - Annual review and updated to new Plan template.
Connection date & details:	November 2016 – Annual review. January 2018 – Annual Review, no updates January 2019 – Annual Review, no updates. January 2020 – Annual Review, no updates.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.