JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE	JOHNS HOPKINS HEALTHCARE	**Policy Number: RPC.013** Effective Date: 6/1/2020 Review Date:
	Subject: Unlisted Codes **Department: Provider Relations** **Lines of Business: EHP, USFHP, PPMCO, and AdvantageMD**	**Page 1 of 4**

ACTION

☒ New Policy

☐ Repealed Policy Date: _____

☐ Superseded Policy Number: _____

The most current version of the reimbursement policies can be found on www.jhhc.com.

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Johns Hopkins HealthCare (JHHC) benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services must be billed with ICD-10 codes, CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Johns Hopkins HealthCare (JHHC) may:

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

JHHC reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state or commercial client contracts, or state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHC strives to minimize these variations.

JHHC reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy on www.jhhc.com.

POLICY

Johns Hopkins HealthCare LLC (JHHC) allows reimbursement for valid unlisted codes with prior authorization supported by the appropriate documentation. Claims submitted with an unlisted procedure code will be denied if determined an appropriate procedure or service code is available, or when no prior authorization was obtained.

This policy statement memorializes JHHC's existing Policy on this subject matter as applied prior to the Effective Date of this policy statement.

SCOPE

This policy applies to claims submitted on the CMS-1500 Claim Form or its electronic equivalent, to a JHHC product, from network and non-network physicians, providers, and suppliers.

DEFINITIONS

Unlisted Codes: A procedure code that represents an item or service for which there is no specific CPT or Level II HCPCS code. These may also be referred to as Not Otherwise Classified (NOC) or Not Otherwise Specified (NOS) codes. Many unlisted codes end in -99.

DOCUMENTATION GUIDELINES

All CPT and HCPCS codes classified as "Unlisted" require prior authorization. Requests for authorization must include supporting documentation to provide an adequate description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Documentation is to include, but is not limited to:

- Medical records (i.e. imaging, lab, operative or office reports, etc.)
- Invoice for unlisted DME or supply codes
- NDC # for unlisted drug codes

PROVIDER BILLING GUIDELINES

When submitting claims with unlisted codes:

- Do not append modifiers to unlisted procedure codes
- Unit value should be reported only once to identify the services provided. If more than one procedure is performed that require the use of the same unlisted code it should be reported only once. Documentation should support and detail additional procedures if submitted for reimbursement.
- No additional reimbursement is provided for special techniques/equipment submitted with an unlisted procedure code.
- Include RVU's, charges, and/or payment for a similar comparable procedure *(the comparable procedure should have a similar approach and similar anatomical site),* or invoice.

Claims submitted without prior authorization will be denied. If an existing or more appropriate code is identified, the claim will be denied.

PAYMENT METHODOLOGY:

Claims submitted with a valid and authorized unlisted code(s) will be reimbursed per the contracted rate for network providers. For non-network providers, reimbursement will not exceed the amount of the closest comparative procedure code.

EXCLUSIONS

N/A

EXEMPTIONS

N/A

REFERENCES: This policy has been developed through consideration of the following:

CMS Publication 100-4, Medicare Claims Processing Manual

32 CFR 199.4(g)(15) – Basic Program Benefits, Exclusions and Limitations

TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 1, Sect. 2.1 - Unproven Drugs, Devices, Medical Treatments, And Procedures

State COMAR 10.67.06.27 -Maryland Medicaid Managed Care Program, Benefits - Limitations

APPROVALS

Reimbursement Policy Committee Date: May 12, 2020

Review/Revision Dates: 5/11/20