Claims and Payment Policy: Review of NOS, NEC, and Unlisted Codes

Policy Number: CPP- 107

BACKGROUND

According to the American Medical Association (AMA), each year in the United States health care insurers process over 5 billion claims for payment. To ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential. Such coding systems include ICD-10 CM (International Classification of Diseases, 10th Edition, Clinical Modification) for diagnosis, CPT-4 Level I (Current Procedural Terminology) for procedures, and HCPCs Level II (Healthcare Common Procedure Coding System) for ambulance services, drugs, products, supplies, and durable medical equipment.

NEC and NOS Code Assignment

ICD-10 CM Official Guidelines for Coding and Reporting FY 2019 states, "While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when unspecified codes such as Not Elsewhere Classified (NEC) or Not Otherwise Specified (NOS) are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter when sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient's condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code."

Unlisted Code Assignment

According to CMS, "An unlisted HCPCS code represents an item, service, or procedure for which there is no specific CPT or Level II alphanumeric HCPCS code. The CPT code book lists a number of unlisted 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. The long descriptors for these codes start with the term "Unlisted" and the last two digits of the codes often end in "99."

When a contractor receives a claim with an unlisted HCPCS code for non-OPPS payment, the contractor shall verify that no existing HCPCS code adequately describes the procedure or service. Unlisted codes should be reported only if no other specific HCPCS codes adequately describe the procedure or service.

CPT Coding and Reporting Guidelines states that providers should "Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code."

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POSITION STATEMENT

Claim submissions that contain procedure codes which are Not Elsewhere Classifiable (NEC), Not Otherwise Specified (NOS), or Unlisted should not be used when a more descriptive diagnosis or procedure code representing the service provided is available. Wellcare will require medical record review for claims submitted with NOS, NEC, or Unlisted procedure codes to determine if the NOS, NEC, or Unlisted procedure code is appropriate. If medical records are not received along with the claims submission for the NOS, NEC, or Unlisted codes, Wellcare will deny the claim until the medical records are received. Documentation may be reviewed for proper coding, existence of a more specific code, appropriate coverage, reimbursement, allowance, and prior notification if needed. The provider will have the option to rebill with the appropriate code.

Documentation is required for all unlisted codes submitted for reimbursement. Documentation is to include, but is not limited to:

- Complete description of what the unlisted code is being used for along with:
- Procedure report for unlisted surgical/procedure codes or
- Invoice for unlisted DME/supply codes
- NDC #, dose and route of administration for unlisted drug codes

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy. If State policies **do not specify coverage provisions**, then the State will follow National coverage guidelines as outlined in this policy

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

PLACE OF SERVICE

Medicaid
Professional: 11, 12, 53, 56, 81, 99
Institutional: 12, 22, 24, 65

Medicare
Professional: 11, 12, 31, 81
Institutional: 65

CODING & BILLING

NOS/NEC Codes:

All applicable NOS/NEC codes as listed in the ICD-10 CM manual. An index can be found here.

Unlisted CPT/HCPCS codes:

Procedure Code Category	Documentation Requirements
Surgical Procedures: All unlisted codes within the range of 10021-69990 and/or by report	Operative or Procedure Report

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Radiology/Imaging Procedures: All unlisted codes within the range of 70010-79999 and/or by report	Imaging Report
Laboratory and Pathology Procedures: All unlisted codes within the range of 80047 -89398 and/or by report	Laboratory or Pathology Report
Medical Procedures: All unlisted codes within the range of 90281-99607 and/ or by report	Office Notes and Reports
Unlisted HCPCS Codes	Operative or Procedure Report
Unclassified Drug Codes	Provide the NDC number with full description/name and strength of the drug and service units
Unlisted DME HCPCS Codes	Provide narrative on the claim; also, if applicable, provide invoice or UPN information.

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

DEFINITIONS

CPT®	Current Procedural Terminology (**CPT®**) is code set is a medical code set maintained by the American Medical Association through the CPT Editorial Panel. The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.
HCPCS	**HCPCS coding** is the standard acronym for Healthcare Common **Procedure Coding** System (**HCPCS**). The system is broken into two subsystems, both designed to help simplify and organize the billions of medical claims that are processed for payment each year in the United States.

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ICD-10 CM	International Classification of Diseases, 10th Edition, Clinical Modification. ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.
NEC	"Not elsewhere classifiable". This abbreviation in the Alphabetic Index of the ICD-10, CPT, or HCPCs manual represents "other specified." When a specific code is not available for a condition, the Alphabetic Index directs the coder to the "other specified" code in the Tabular List.
NOS	"Not otherwise specified" .This abbreviation is the equivalent of unspecified.
"Other" Codes	Codes titled "other" or "other specified" are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with NEC in the line designate "other" codes in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an "other" code.
Unlisted Codes	An unlisted HCPCS code represents an item, service, or procedure for which there is no specific CPT or Level II alphanumeric HCPCS code. The long descriptors for these codes start with the term "Unlisted" and the last two digits of the codes often end in "99."
Unspecified Codes	Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the "other specified" code may represent both other and unspecified.

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REFERENCES

1. CMS Pub. 100-04, Medicare Claims Processing, Transmittal 1657, Section 4/180.3, Unlisted Service or Procedure. Available https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1657CP.pdf

2. Current Procedural Terminology (CPT®), 2019

3. HCPCS Level II, 2019

4. International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), Official Guidelines for Coding and Reporting, FY 2019

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.

The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.

References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.Wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
03/23/2020	Approved by RGC

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