FAQs

Utilizing Unlisted CPT Codes

When seeking reimbursement for services or procedures, it is important for providers to select the Current Procedural Terminology (CPT)* code that accurately and precisely describes that which is provided. If no specific CPT code exists, the provider should report the service using an appropriate "unlisted" CPT code. This guidance may be applicable when new procedures and/or technology become available without a specific CPT code which adequately describes it. Please see the information below on suggested steps to authorize and report unlisted procedure codes. Providers are encouraged to consult their own experts for advice regarding reimbursement, coding, and coverage issues related to the use of unlisted procedure codes.

What is an unlisted CPT code?

An unlisted CPT code represents an item, service, or procedure for which there is no specific CPT or Level II alphanumeric HCPCS code. Some examples of unlisted codes used in otorhinolaryngological services include:

- CPT 69399 - Unlisted procedure, other procedures of the external ear
- CPT 69799 - Unlisted procedure, other procedures of the middle ear
- CPT 92700 - Other otorhinolaryngological services or procedures

Since unlisted codes do not identify the usual procedural components or the effort/skill required for the service, there are no relative value units or payment rates assigned to them. When using an unlisted code, the provider is required to share specific information regarding the procedure(s) identified by the code (i.e., clear description of the nature, extent, and need for the procedure/service including time, effort, and equipment necessary to provide the service).

Can I choose a code that is close to the description of the service provided?

When seeking reimbursement for services, it is important to select the Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) Level II code that accurately and precisely describes the services provided. If no specific CPT or HCPCS code exists, the procedure must be reported using an appropriate "unlisted" CPT code.

While the use of an unlisted procedure code requires a special report or documentation to describe the service, correct coding demands that the code reported is appropriate for the service provided (i.e., a code that most accurately represents the service provided), and not a code that is similar but actually represents another service. CPT Assistant December 2010

When reporting unlisted codes, such as 69799, it will likely be necessary to provide supporting documentation that provides an adequate description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service. It may be helpful to describe the similarity to and differences with the current family of AOI codes (69714-69715) and also include the appropriate device code, L8690: Auditory osseointegrated device, includes all internal and external components.

Unlisted/unspecified codes, like CPT 69799, do not have payment rates assigned to them because they do not describe a specific procedure or service. Therefore, it is prudent to work with the payer to establish payment rates in advance of the procedure. Establishing the value of the procedure relative to another procedure often is the best way to facilitate claim adjudication. Payers will manually price services based on the documentation provided.

How do I prior authorize an unlisted code?

The prior authorization process remains the same when submitting requests for unlisted procedure codes; however, providers should be prepared to provide additional information to the payer. The provider should be prepared to communicate a detailed description of the service to ensure the payer understands the request and communicate the medical necessity of the requested procedure. Providers are encouraged to provide supporting documentation that provides an adequate description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service.

Providers should appeal any potential denials for prior authorization with communication that justifies the medical necessity of the procedure. A cover letter that outlines the amount of time, work, technical expertise and use of equipment necessary to perform the procedures may further support this process. It may be helpful to describe the similarity to and differences with the current family of AOI codes (CPT 69714-69715) and also include the appropriate device code, L8690: Auditory osseointegrated device, includes all internal and external components.

* Please see an attached sample cover letter which providers may adapt and consider submitting with requests for authorization and/or payment requests to payers.

As a reminder, traditional Medicare does not allow for prior authorization. Providers should be prepared to submit a short description of the service provided when submitting their claim for payment. Additional documentation may be required and/or requested by any payer to adjudicate the claim.

Payers may reject the need for a prior authorization of CPT 69799 because it does not appear on their prior authorization list. In cases where payers require the use of CPT 69799 and reject the ability to authorize that code, an alternative may be to seek authorization through a pre-determination of benefits request rather than a prior authorization request. The differences between the two requests are shown below.

What is the difference between prior authorization and predetermination?

Prior authorization is a process used to confirm the procedure is: • Medically necessary • Covered for the proposed care • Covered for the proposed length of stay • Scheduled for review	Predetermination confirms eligibility and collects information before procedures and services and includes: • Notification – process of documenting coverage requests • Coverage Determination – review of plan documents and submitted clinical information to determine whether the health plans clinical guidelines and criteria are met for coverage

Please note that a service that has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

Can I use modifiers with unlisted codes?

The use of modifiers with unlisted codes is not appropriate or recommended. Modifiers are intended to communicate that a service or procedure has been altered by a specific circumstance. Since unlisted codes do not describe specific services, it is not necessary or appropriate to utilize modifiers. CPT Assistant August 2002

How is payment determined for an unlisted code?

Most payers will review documentation submitted by the provider as well as information on comparable procedures to establish payment for an unlisted code. When reporting unlisted procedure codes, such as CPT 69799, it will likely be necessary to provide supporting documentation that provides an adequate description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service.

In those instances where an unlisted procedure code is reported without prior authorization (for example, traditional Medicare), a copy of the operative report should be submitted, along with supporting information outlining the decision-making process and the medical rationale for performing the operation. For Medicare patients, this documentation should be submitted to the appropriate Medicare Administrative Contractor (MAC). When submitting an unlisted procedure code, a concise description of the procedure should be included in Item 19 of the CMS-1500 paper form or its equivalent on an electronic media claim (EMC) form.

Providers are encouraged to review the remittance advice for payment as claims are adjudicated.

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The health care provider is responsible for determining the medical necessity of a product for the HCP's patient. This example letter does not provide medical or legal advice about what is or may be medically necessary. This is merely an example letter that sets forth a sample format to communicate the amount of time, work, technical expertise and use of equipment necessary to perform a procedure and request authorization and permission to report an unlisted CPT code. This example may not be applicable to all situations and is no guarantee of coverage.

(Date)

Attn: (Contact Name)

(Title)

(Insurance Company Name)

(Address)

Re: (Patient's Name)

Date of Birth: _____ Dates of Service: _____

Group Number: _____ Subscriber/Policy Number:_____

Dear (Contact Name):

On (date of service), I performed a (name of procedure) on the above-mentioned patient. (Patient's Name) was diagnosed with (Diagnosis). This patient also has (List any associated symptoms or co-morbidities). (If applicable, include additional information such as alternative treatments that have failed.)

According to guidance offered by the CPT Assistant FAQ published in January 2019, the appropriate code for reporting a surgery in which an "osseointegrated bone-conduction hearing system that uses magnetic connection and coupling is implanted" is CPT 69799: unlisted procedure, other procedures of the middle ear. This procedure may be reasonably compared to the existing AOI category CPT code (CPT 69714/69715) in terms of physician work and practice expense. Additionally, the HCPCS code L8690: Auditory osseointegrated device, includes all internal and external components, represents the implantable hearing device. (Inform the payer on specific details of the service; providing clear description of the nature, extent, and need for the procedure/service as well as time, effort, and equipment necessary to provide the service. Include information to support both the similarities and differences of this procedure to that represented by the comparable CPT code.)

My charge for (i.e., comparator CPT code 69714 or 69715) is $_____. I estimated the charge for the submitted unlisted procedure to be (list percentage that current procedure is less or more difficult than the comparator code) for the reasons mentioned above. Therefore, I have submitted a charge of $_____ for this procedure. Attached, please find a detailed copy of my operative report, office notes, published articles supporting this procedure and a claim form for (patient's name).

Sincerely,

(Physician's Signature)

(Practice Name)

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