Unlisted, Unspecified & Misc. Codes

Reimbursement Policy

Policy

Providers must submit CPT/HCPCS code(s) to the highest specificity, if none are available, an unlisted code may be appropriate. Unlisted, unspecified, or miscellaneous CPT/HCPCS codes are only permissible when an established code does not exist to describe the drug, service, supply, implant, procedure or item rendered. Community Health Options reimbursement is based on the review of the unlisted, unspecified or miscellaneous codes on an individual authorization and claim basis. Authorizations and claims submitted with unlisted, unspecified or miscellaneous codes must contain the following information and/or documentation to accurately review for coverage against a Member's Benefit Agreement, Medical Management authorization requirements and Community Health Options' policies:

- A written description, office notes, or operative report that certifies the medical necessity for the unlisted, unspecified, or miscellaneous item, service, or supply
- An invoice and written description that identifies the unlisted, unspecified, or miscellaneous item, service, or supply
- Number of times service or item was provided
- Date(s) the service or item was provided
- Identification to support if service or item performed independently from other services or performed at the same surgical site
- The corresponding National Drug Code (NDC) number for an unlisted drug code

Because unlisted, unspecified, or miscellaneous codes could represent more than one service or procedure, Community Health Options payment schedules do not include reimbursement rates. Specific fee allowances and/or Relative Value Units (RVUs) cannot be established for unlisted services/items. Once the unlisted, unspecified, or miscellaneous code is determined to be a covered service, Community Health Options will determine the reimbursement rate according to standard industry reimbursement methodologies.

Non-Covered Services

- Claims submitted without supporting documentation or information as listed above
- Claims submitted with unlisted/unspecified/misc. code will be denied if determined a more appropriate procedure or service code is available
- Claims submitted with unlisted/unspecified/misc. code when used for computer-assisted or robotic surgery
- Claims submitted with unlisted/unspecified/misc. code for an item/service "unbundled" from a more comprehensive billed charge. Community Health Options may view the deliberate use of inappropriate unlisted/unspecified/misc. codes for maximizing payments or "unbundling" procedures as fraudulent billing practices.
- Supplies or equipment submitted with an unlisted/unspecified/misc. code.
- Unlisted/unspecified/misc. codes identified as experimental/investigational.

Related Policies

Ambulance Services
Surgery: Computer-Assisted / Robotic

Document Publication History

- 1/6/2023 Initial publication

This policy provides information on Community Health Options' claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. Community Health Options reserves the right to amend a payment policy at its discretion. Policies are enforced unless the underpinning direction stated otherwise.