Billing and Reimbursement Guideline:	**Unlisted/Unspecified Procedure Codes**

Guideline Publication Date:	**September 1, 2010**

Key coding, documentation and reimbursement points include:

- Services billed with unlisted procedure codes or a "not otherwise classified" code require supporting documentation prior to consideration of payment. Most sections of the CPT® code book contain codes for billing procedures and services that are not otherwise classified or described within the codes.

- Unlisted procedures should only be billed when no other code is appropriate. Providers should bill with the closest or most similar unlisted code.

- The medical report that accompanies the claim should include the following:
  - Nature and extent of the procedure performed
  - Medical necessity of the procedure performed
  - Total time, effort, and equipment needed
  - Complexity of the symptoms, final diagnosis, physical findings, concurrent problems, and follow-up care

- Procedures or devices deemed experimental or that are not FDA approved are not covered.

- This guideline applies to both CMS-1500 and UB-92 claim submissions.

- This guideline applies to all places of service.

Please refer to Neighborhood's provider website at http://www.nhpri.org for specific provisions by product line.

This guideline is not a guarantee of reimbursement. Plan coverage, eligibility and claim payment edit rules may apply.

Version History

Original Publish Date:	9/1/2010
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9/1/2013	Format change, minor edits