Payment Policy

Unlisted Procedures & Services

Purpose

The purpose of this payment policy is to define what Minuteman Health, Inc. (MHI) requires when submitting a claim for an unlisted procedure or service.

Applicable Plans

☒ MHI MA Plans
☒ MHI NH Plans

Definitions

An unlisted procedure code provides the means of reporting procedures or services that do not have an established CPT/HCPCS code.

Requirements

A. Documentation

When submitting an unlisted procedure or service on a claim, the pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary for the procedure.

In addition to the required documentation:

- Provide a cover letter outlining the need for an unlisted code and how the charges are derived.
- Underline or highlight the portion of the report that identifies the test or procedure associated with the unlisted procedure code.

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Refer to the table below for documentation requirements:

Procedure Code Category	Documentation Requirements
Surgical procedures	Operative or procedure report
Radiology/imaging procedures	Imaging report
Laboratory and pathology procedures	Laboratory or pathology report
Medical procedures	Office notes and reports
Unclassified drug codes	Submit the unlisted code: • NDC number with full description/name and strength of the drug and service units • Current invoice
Unlisted DME HCPCS codes	Provide narrative on the claim

A service that is rarely provided, unusual, variable, or new may require a special report.

B. Processing Guidelines

- MHI will determine whether the unlisted procedure is a covered benefit or service upon review of the submitted documentation.
- Supporting documentation may be subject to Medical Director review.
- An unlisted procedure code will be denied if it is determined there is a more appropriate procedure or service code that most closely approximates the service performed.
- Claims billed with unlisted procedure codes without supporting documentation will be denied.

Authorization Requirements

Refer to the Provider Manual for guidance on prior authorization requirements.

Attachments

None

Important Note About This Reimbursement Policy

Providers are responsible for submission of accurate claims. All EDI claims must be submitted in accordance with HIPAA 5010 Standards and Paper claims must be submitted on either CMS1500 or CMS1450 (UB04) claim forms. MHI's reimbursement policy includes the use of Current Procedural

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Terminology (CPT®[1]), guidelines from the Centers for Medicare and Medicaid Services (CMS), and other coding guidelines. Providers will be reimbursed based on the codes(s) that correctly describe the health care services provided.

MHI may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to MHI enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, the type of provider agreement and the terms of that agreement, the MHI Provider Manual, and/or the enrollee's benefit coverage documents.

MHI reserves the right to audit any provider and/or facility to ensure compliance with the guidelines stated in this payment policy in accordance with our provider review policy.

Resources

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
MHI provider Manual

History

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[1] CPT® is a registered trademark of the American Medical Association.