HAP CareSource™

REIMBURSEMENT POLICY STATEMENT
Michigan Marketplace

Policy Name & Number	Date Effective
Unlisted and Miscellaneous Codes-MI MP-PY-1487	01/01/2025
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.
CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Unlisted and Miscellaneous Codes

B. Background

Reimbursement policies are designed to assist providers when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify a member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Current Procedure Terminology (CPT) codes are used to describe medical procedures and physician services. The American Medical Association (AMA) maintains and distributes CPT codes. Health Care Common Procedure Coding System (HCPCS) code set represents items, supplies, and non-physician services not addressed by the CPT codes. The Centers for Medicare and Medicaid Services (CMS) establishes and maintains the HCPCS codes. These code sets were established so providers can use the most specific and appropriate code when submitting claims for reimbursement of services rendered to members.

Occasionally, a CPT/HCPCS code may not be available for a procedure or service if it is rarely used, unusual, or new. Only then would providers use an unlisted, unclassified, not otherwise specified (NOS), not otherwise classified (NOC), unlisted, miscellaneous, or generic code for any such procedure, service, item, supply, or non-physician service.

C. Definitions

- **Durable Medical Equipment (DME)** – Equipment and supplies ordered by a health care provider for everyday or extended use.
- **Miscellaneous (Unlisted, Unclassified, Not Otherwise Specified (NOS,) or Not Otherwise Classified [NOC]) Codes** – Submitted by a supplier for an item or service for which there is no existing code that adequately describes the item or service being billed.

D. Policy

I. All unlisted or miscellaneous codes require a prior authorization and medical necessity review.

II. Unlisted or miscellaneous codes should only be used when an established code does not exist to describe the diagnosis, service, procedure, or item rendered.

III. Reimbursement is based on review of the unlisted or miscellaneous code(s) on an individual claim basis.

IV. Prior authorization submitted with unlisted or miscellaneous codes must contain the applicable information and/or documentation below for consideration during review:
   A. a complete description of the item (including, as applicable, the manufacturer, model or style, and size), a list of all bundled components, and an itemization of all charges, including an invoice
   B. statement that no other code exists that would be more appropriate
   C. any other information requested by CareSource

V. Unlisted/non-specific codes used for procedures deemed to be experimental and investigational may be denied.

VI. Warranty
CareSource may request warranty information regarding the DME item or supply when an unlisted or miscellaneous code is used. If the requested DME item(s) and/or supplies are covered by the supplier's or manufacturer's warranty, CareSource will deny the prior authorization.

VII. The following codes are not all inclusive but provide a general reference of unlisted/miscellaneous codes that are generally used incorrectly.

Code	Description
A4335	Incontinence supply; miscellaneous
A4421	Ostomy supply; miscellaneous
A9999	Miscellaneous DME supply or accessory, not otherwise specified
B9998	Not otherwise classified (NOC) for enteral supplies
E1399	Durable medical equipment, miscellaneous
K0108	Wheelchair component or accessory, not otherwise specified
Q0507	Miscellaneous supply or accessory for use with an external ventricular assist device
Q0508	Miscellaneous supply or accessory for use with an implanted ventricular assist device

E. Conditions of Coverage

A. All unlisted or miscellaneous codes defined within this policy are subject to medical necessity review and prior authorization.
B. Prior authorization is not a guarantee of payment.
C. Claims must include an invoice.
D. CareSource may verify the use of any code through post-payment audit.

E. If a more appropriate code is discovered, CareSource may request recoupment.

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	09/11/2024	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2025	
Date Archived		

H. References

1. CPT® overview and code approval. American Medical Association. Accessed June 20, 2024. www.ama-assn.org
2. Durable Medical Equipment (DME). Accessed June 20, 2024. www.healthcare.gov
3. Healthcare Common Procedure Coding System (HCPCS). American Medical Association. Accessed June 20, 2024. www.ama-assn.org