curative

TITLE:	UNLISTED, UNSPECIFIED, MISCELLANEOUS, AND NOT OTHERWISE CLASSIFIED PROCEDURES AND SERVICES
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	03/16/2026
REVISION DATE:	N/A

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers. Curative will allow reimbursement for services according to the criteria outlined in this policy, unless modified or superseded by contractual language.

3. DEFINITIONS

The following terms are defined as follows regarding this policy.

3.1. **Miscellaneous Code** A code identifying supplies, equipment or drugs for which there is no existing code that adequately describes the item.

3.2. **Not Otherwise Classified Code** A code identifying supplies, equipment or drugs for which there is no existing code classification.

3.3. **Unlisted Code** A code identifying a procedure or service for which there is no existing code that adequately describes the service.

3.4. **Unspecified Code** A code identifying a procedure or service for which the information provided is not detailed enough to use a more specific code available.

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member's benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. To ensure accurate reimbursement and proper claims adjudication, all services provided to the same member, by the same provider, and on the same date of service must be reported on a single claim. Current Procedure Terminology (CPT®*) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts, state or federal laws, or requirements issued by the Centers for Medicare & Medicaid Services (CMS). Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

Reimbursement Guidelines

CPT and HCPCS codes defined as Unlisted, Unspecified, Miscellaneous or Not Otherwise Classified are considered for reimbursement by Curative in appropriate circumstances. These codes should only be reported when there is not a specific code already established to describe the service or item. Providers should always report the CPT or HCPCS code that most accurately describes the administered drug(s), service(s) or procedure(s) performed and report.

When reporting an Unlisted, Unspecified, Miscellaneous or Not Otherwise Classified code, the most specific code available for the service should be chosen. There are codes available in general code sections as well as specific sections depending on the service. For example, separate unlisted codes are available for shoulder procedures (23929) and there is also a general musculoskeletal system code available (20999).

Reimbursement for proper use of the code will be considered on an individual basis according to the below guidelines.

Billing Specifications

To bill for Unlisted, Unspecified, Miscellaneous or Not Otherwise Classified codes the below guidelines should be followed.

- The codes must be reported with a unit value of 1. If multiple categories of codes are billed, each must be reported separately with a unit value of 1.

- For professional billing or facility billing, claims for unlisted drug codes are requested to include the National Drug Code (NDC) number and the narrative description including the dosage administered.

Supporting Documentation

Due to the fact that Unlisted, Unspecified, Miscellaneous and Not Otherwise Classified CPT or HCPCS codes do not describe in detail what was performed or rendered as part of the procedure or service, Curative may request supporting documentation to be submitted.

Documentation for the different categories of Unlisted, Unspecified, Miscellaneous, or Not Otherwise Classified Codes should include the below.

Services and Procedures

- A clear, detailed description of the extent and need for the procedure or service
- Relevant office notes or a full operative report describing the procedure performed
- Any extenuating circumstances which may have complicated the procedure or service
- Time, effort, and equipment necessary to provide the service
- If there is a similar or like CPT or HCPCS code existing but is not appropriate in this situation

Items and Supplies

- An itemized invoice containing a written description of all items or supplies

Unlisted Drugs and Biologicals

- The National Drug Code (NDC) number
- The specific drug name and exact dosage administered

Claims submitted will be denied if it is determined that a more appropriate procedure/service code is available. Reimbursement is contingent upon provider, state, and federal contracts, and is subject to review on an individual claim basis.

Avoiding Common Denials

- Always utilize a specific CPT® or HCPCS code when available
- Append modifier 22, increased procedural service, when appropriate
- Do not use these codes to identify the use of a special techniques or equipment

5. REFERENCE DOCUMENTS AND MATERIALS

5.1. American Medical Association (AMA)

5.2. Centers for Medicare and Medicaid Services (CMS), CMS Manual System and other CMS publications and services

5.3. Centers for Medicare and Medicaid Services (CMS), Healthcare Common Procedure Coding System, (HCPCS) Release and Code Sets

5.4. Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services

6. COLLABORATING DEPARTMENTS

6.1. Claims

6.2. Compliance

6.3. Medical Management

6.4. Network

6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
03-16-2026	CJ Wisecarver	001	Initial Version