Reimbursement Policy	
Subject: **Unlisted or Miscellaneous Codes**	
Policy Number: **G-06004**	Policy Section: **Coding**
Last Approval Date: **04/11/2022**	Effective Date: **04/11/2022**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to https://providers.anthem.com/ny**.** ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem Blue Cross and Blue Shield Retiree Solutions Medicare Advantage covered the service for the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or

requirements. Anthem Medicare Advantage strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem Medicare Advantage allows reimbursement for unlisted or miscellaneous codes unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. Unlisted or miscellaneous codes should only be used when an established code does not exist to describe the diagnosis, service, procedure, or item rendered.

Reimbursement is based on review of the unlisted or miscellaneous code(s) on an individual claim basis. Claims submitted with unlisted or miscellaneous codes must contain the applicable information and/or documentation below for consideration during review:

- A written description, office notes, or operative report describing the procedure or service performed
- An invoice with written description of items and supplies
- The corresponding National Drug Code number for an unlisted drug code

Related Coding
Standard correct coding applies

Policy History	
04/11/2022	Biennial Review Approved and effective: Updated policy template, clarified policy language, removed **Unspecified** from policy language, updated Definition section
07/29/2019	Biennial review approved and effective 08/01/2020
08/31/2017	Review approved and effective 07/01/2018; Policy language updated; Policy template updated
11/04/2015	Biennial review approved; Policy language updated
01/01/2015	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • State contract • Federal Register

Definitions	
Miscellaneous	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
Unlisted	An unlisted HCPCS code represents an item, service, or procedure for which there is no specific CPT or Level II alphanumeric HCPCS code. The CPT code book lists a number of unlisted service or procedure codes, which can be found at the end of a section or subsection. Alternatively, a summary list of the unlisted CPT codes can be found in the Guidelines section for each chapter of the CPT code book. The long descriptors for these codes start with the term **Unlisted** and the last two digits of the codes often end in **99**.
General Reimbursement Policy Definitions	

Related Policies and Materials
Claims Requiring Additional Documentation