	Reimbursement Policy
Subject: Unlisted, Unspecified or Miscellaneous Codes	
Effective Date: **08/01/20** | Committee Approval Obtained: **7/29/19**	Section: **Coding**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://mediproviders.anthem.com/ky/pages/reimbursementpolicies.aspx**.*****

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield Medicaid (Anthem) if the service is covered by a 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 CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

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

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

Anthem reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

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

	• Community mental health centers to bill unlisted psychiatric service or procedure codes with an applicable modifier without documentation of a written description, office notes or operative report. • Child advocacy centers to bill unlisted evaluation and management services without documentation of a written description, office notes or operative report. Reimbursement is based on review of the unlisted, unspecified or miscellaneous codes on an individual claim basis. Claims submitted with unlisted, unspecified or miscellaneous codes must contain the following information and/or documentation for consideration during review: • A written description, office notes or operative report describing the procedure or service performed • An invoice and written description of items and supplies • The corresponding National Drug Code number for an unlisted drug code
History	• Biennial review approved **07/29/19** and effective **08/01/20**: Policy language updated; diagnosis bullet removed • Review approved **08/31/17** and effective **07/01/18**: Policy language updated; Policy template updated • Biennial review approved **11/04/15**: Policy language updated; Policy template updated • Review approved **10/13/14** • Initial approval and effective date **01/01/14**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contract

Definitions	• **Unlisted or Miscellaneous Codes** are used for service(s) or item(s):
	  ○ Not having a designated code fitting the description of the service(s) or item(s) rendered.
	  ○ To circumvent:
	  ▪ Code edit software logic, such as:
	  • Duplicate claim.
	  • Incident to.
	  • Mutually exclusive.
	  • Unbundling logic.
	  ▪ Benefit limitations and exclusions.
	  ▪ Fee allowances.

	Unlisted or miscellaneous codes may be used for a variety of services or items. As new and advanced approaches and techniques are under development, the unlisted category is used for auditing purposes until these procedures become accepted in medical practice and are routinely performed by providers. Specific fee allowances and/or relative value units cannot be established for Unlisted services or items. • **General Reimbursement Policy Definitions**
Related Policies	• None
Related Materials	• None