Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Unlisted, Unspecified or Miscellaneous Codes		
Effective Date: **08/01/20**	Committee Approval Obtained: **07/29/19**	Section: **Coding**

*****The most current version of the 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://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicaid. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup 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, Amerigroup may:

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

Amerigroup 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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, Amerigroup strives to minimize these variations.

Amerigroup 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	Amerigroup 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. 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
Exemptions	• Amerigroup Community Care in Georgia allows reimbursement of unlisted codes without documentation of an invoice. • Amerigroup — Texas allows: o Reimbursement for unlisted, unspecified or miscellaneous procedure codes when submitted on paper with accompanying documentation. • Documentation for drugs must include the drug name and NDC number, quantity/units, brief description of the recipient's condition(s) that supports the medical need for the drug and a copy of the drug invoice. o Reimbursement of unlisted enteral supplies codes submitted without documentation of a written description, office notes or operative report when the code is appended with the applicable modifiers U1-U5. o Nursing facilities to bill unlisted tracheostomy care procedures without documentation of a written description. • Note: For the above exemptions, Amerigroup reserves the right to request medical records to support the claim. If the documentation indicates a more appropriate code exists or a definition is provided that does not support the state exemption, the claim may be subject to the standard unlisted code policy.
History	• Biennial review approved **07/29/19** and effective **08/01/20**: Georgia and Texas exemptions updated; Kansas exemption removed • Review approved **09/28/17**: Georgia exemption added • Review approved **08/31/17** and effective **07/01/18**: Policy language updated; Maryland exemption removed

	• Review and effective **01/03/17**
	• Biennial review approved **11/04/15**: Policy language updated; Maryland exemption added; Texas exemption updated
	• Effective **05/01/16**: Kansas exemption added
	• Effective **06/01/15**: Kansas exemption removed
	• Review approved **10/13/14** and effective **07/29/13**: Background and policy template updated; Exemptions effective as follows:
	  ○ Effective **03/01/15**: Texas exemption updated
	  ○ Effective **08/04/14**: Kansas exemption updated
	• Effective **06/01/14**: Ohio exemption removed
	• Review approved **12/02/13**: Kansas exemption added
	• Biennial review approved **11/18/13** and effective **07/29/13**: Language updated; Disclaimer updated **07/29/13**
	• Biennial review approved **11/21/11**: Accountability language updated
	• Review approved and effective **09/13/10**: Texas exemption added; Background section and policy template updated
	• Review approved **09/21/09** and effective as follows:
	  ○ Effective **11/01/09** for New Jersey
	  ○ Effective **10/11/09** for all other and new Amerigroup markets
	  ○ Summary of changes: Policy language updated
	• Review approved **10/06/08**
	• Review approved **05/29/07**
	• Review approved **04/10/07**: Policy language updated
	• Initial approval and effective date **03/02/06**

References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts

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