



Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHPlus), and Essential Plan members. Please note, this information is specific to the MMC, HARP, CHPlus, and Essential Plan programs only.

Reimbursement Policy	
Subject: Unlisted or Miscellaneous Codes	
Policy Number: G-06004	Policy Section: Coding
Last Approval Date: 11/04/2024	Effective Date: 11/04/2024

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

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Highmark BCBS covered the service for the member's benefit plan. The determination that a service, procedure, and/or item 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, Highmark BCBS may:

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

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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

Highmark BCBS allows reimbursement for unlisted or miscellaneous codes unless provider, state, federal, or CMS contracts or requirements indicate otherwise. Unlisted or miscellaneous codes should be used only 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 codes on an individual claim basis. Claims submitted with unlisted or miscellaneous codes should 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 (NDC) for an unlisted drug code

Related Coding

Standard correct coding applies

Policy History

11/04/2024	Review approved and effective: no changes
04/11/2022	Review approved and effective: updated policy template; clarified policy language; removed <i>Unspecified</i> from policy language; updated Definition section
07/29/2019	Review approved 07/29/2019 and effective 08/01/2020: Policy language updated; Diagnosis bullet removed
08/31/2017	Review approved 08/31/2017 and effective 07/01/2018: Policy language updated; updated policy template
11/04/2015	Initial approval 11/14/2015 and effective 01/01/2017

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Federal Register
- State contract
- State Medicaid

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 has several unlisted service or procedure

	codes at the end of a section or subsection. The CPT code book also has a summary of the unlisted CPT codes in the Guidelines section for each chapter. The long descriptors for these codes start with the term <i>Unlisted</i> and the last two digits of the codes often end in 99.
General Reimbursement Policy Definitions	

Related Policies and Materials
Claims Requiring Additional Documentation

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