REMINDER: Unlisted Codes

CPT ® Procedure or Service Codes

Per the American Medical Association Introduction section guidelines[1]: CPT® Category I (CPT®) and Category III (temporary codes emerging technologies) codes describe the majority of procedure and services currently performed and should be used to report these procedure and services that are accurately described in existing CPT® codes. However, there are instances when a specific code may not exist, and an unlisted procedure or service code may be reported, and CPT® guidelines should be adhered to when reporting an unlisted procedure or service code. Each unlisted procedure or service code relates to a specific section of the code set and is presented in the guidelines of that defined section.

CPT® 'unlisted procedure or service codes' end in XXX99 and will be noted in the code descriptor in the end of each section of specific section of the code set.

Providers should always bill a defined procedure or service code when one is available. If a defined code is not available, services can be billed using the unlisted code. HOWEVER, the claim must be submitted on paper with the office and/or operative notes and include a written description of the service that was rendered and being billed as an unlisted service. The written description must be clearly visible and not just part of the medical notes. It can be listed on the claim or written on the cover page/first page of the medical notes. The claim will be reviewed for determination of benefit.

Note: Some of the unlisted procedure or service codes may require prior approval. When this occurs, claims are not reviewed for benefit determination, but rather the claim processes based on the status of the prior approval

Level II HCPCS Codes

Whan a code for a specific procedure is not listed. The code description may include any of the following terms: unlisted, not otherwise classified (NOC), unspecified, unclassified, other and miscellaneous.

Providers should always bill a defined procedure, service or supply code when one is available. If a defined code is not available, services can be billed using the unlisted Level II HCPCS procedure, service or supply code. However, the claim must be submitted on paper with the office and/or operative notes and include a written description of the service that was rendered and being billed as an unlisted service. The written description must be clearly visible and not just part of the medical notes. It can be listed on the claim or written on the cover page/first page of the medical notes. The claim will be reviewed for determination of benefit**.**

Note: Some of the unlisted service codes may require prior approval. When this occurs, claims are not reviewed for benefit determination, but rather the claim processes based on the status of the prior approval (for example, compound drugs, such as J7999).

Reference:

[1]American Medical Association. (2025). CPT®: Current Procedural Terminology (Professional). Chicago IL: American Medical Association.