Understanding the Updated Guidance for Reporting Unlisted Codes in the CPT 2024 Code Set

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Important changes were made for reporting unlisted codes in the CPT 2024 code set. The changes required a significant amount of work by a special AMA workgroup that collaborated with all relevant stakeholders over the last 2 years. The workgroup and specialty societies involved were tasked with reviewing the entire CPT code set to ensure that the guidance changes are congruent and consistent across multiple categories of codes. The final changes that were implemented in the CPT 2024 code set represent a new paradigm for reporting unlisted procedure codes. This article provides an overview of these changes to help users understand how to correctly report unlisted codes effective January 1, 2024. It is important to note that the guidance in this article supersedes all other guidance for reporting unlisted codes previously published in CPT Assistant.

To highlight the changes, many new instructional guidelines on the proper use of unlisted codes were added throughout various sections and subsections of the CPT® 2024 codebook, especially in the Introduction section where instructions and guidance for using the CPT codebook and for reporting unlisted procedures or services are included. The new guidelines also include helpful examples of when specific and unlisted codes are appropriately reported together and when they may not be reported together. The new guidelines and examples, which are available on pages xv-xix of the CPT® 2024 codebook, are presented below and should be reviewed carefully.

Instructions for Use of the CPT Codebook

Select the CPT code of the procedure or service that accurately identifies the procedure or service performed. Do not select a CPT code that merely

approximates the procedure or service provided. If no such specific code exists, then report the procedure or service using the appropriate unlisted procedure or service code. When using an unlisted code, any modifying or extenuating circumstances should be adequately and accurately documented in the medical record.

Because Category I or Category III codes may incorporate multiple components (bundled) that could be reported separately with other existing codes, “unbundling” of codes into their component parts for reporting purposes or combining those components with an unlisted code is inappropriate. For example, it would be inappropriate to separately report both codes 42825, Tonsillectomy, primary or secondary; younger than age 12, and 42830, Adenoidectomy, primary; younger than age 12, for removal of the tonsils and adenoids, because these two procedures are reported together using code 42820, Tonsillectomy and adenoidectomy; younger than age 12. Multiple Category I or Category III codes may be reported together to describe the totality of service rendered for a given patient encounter if they represent separately reportable services. Individual components of a procedure or service specified as part of a Category I or Category III code descriptor are reported neither separately with an existing CPT code nor with an unlisted code. Procedural steps necessary to reach the operative site and to close the operative site are also not reported separately, unless otherwise instructed by CPT guidelines or parenthetical notes. For example, a laparoscopic cholecystectomy should not be reported together with a code for the incision or a code for the repair of the surgical wound because these are inherent procedural steps needed to accomplish the cholecystectomy. However, if an excision of a benign lesion requires a complex repair for closure, both the lesion excision and the complex repair code are reported separately because the Repair (Closure) Guidelines indicate that “complex repair does not include excision of benign (11400-11446) or malignant (11600- 11646) lesions.”

Unlisted Procedure or Service

Category I and Category III codes describe the vast majority of procedures and services currently performed in the United States and should be used to report these procedures and services that are accurately described in existing CPT codes. It is recognized that there may be services or procedures performed by physicians or other qualified health care professionals (QHPs) that are not found in the CPT code set. Therefore, a number of specific code numbers have been designated for reporting unlisted procedures. When an unlisted procedure code is used, the service or procedure should be described (see specific section guidelines). Each of these unlisted codes (with the appropriate accompanying topical entry) relates to a specific section of the code set and is presented in the guidelines of that section.

The CPT code set's instructions to use an unlisted procedure code do not preclude the reporting of an appropriate code that may be found elsewhere in the CPT code set. It may be appropriate to report multiple Category I or Category III codes together to describe the totality of a service rendered for a given patient encounter, provided each code represents a separately reportable service. Similarly, it is appropriate to report an unlisted code together with a Category I or Category III code(s) for the same patient encounter on the same date of service when a separately reportable portion of a provided procedure or service is not described by an existing CPT code(s).

Example

Reporting unlisted code(s) with Category I code(s): When both radiofrequency ablation of the greater saphenous vein and stab phlebectomy using less than 10 incisions are performed in the same operative session, both codes 36475, Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated, and 37799, Unlisted procedure, vascular surgery, may be reported because there is no code for stab phlebectomy with less than 10 incisions.

While uncommon, if multiple separately reportable unlisted services are performed on the same patient on the same date of service by the same physician or other QHP, then multiple unlisted codes may be reported. If the two procedures are performed in the same anatomic region, then multiple units of the same unlisted code may be reported with modifier 59 appended to the additional unit(s). If two unlisted services are performed in two different anatomic regions, then two different unlisted codes may be reported.

Example

Reporting multiple separately reportable unlisted services: If two unlisted arthroscopic procedures are performed on two separate joints by the same surgeon on the same date of service, then two units of 29999, Unlisted procedure, arthroscopy, may be reported with modifier 59 appended to the second unit.

Note that unlisted codes are not used to separately report component(s) of an existing Category I or Category III service.

Example

It would not be appropriate to use 39599, Unlisted procedure, diaphragm, to separately report suturing of the diaphragm performed as a component of a

paraesophageal hernia repair, which is reported with code 43281, Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh.

Because unlisted codes do not include descriptor language that specifies the components of a particular service, modifiers that describe alteration of a service or procedure may not be used. For example, it would not be appropriate to append modifier 52, Reduced Services, to an unlisted code. However, modifiers to indicate laterality (ie, modifier 50, Bilateral Procedure); distinction (ie, modifier 59, Distinct Procedural Service); assistant-at-surgery (modifier 80, Assistant Surgeon); and place of service (eg, modifier 95, Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System; modifier 93, Synchronous Telemedicine Service Rendered Via Telephone Or Other Real-Time Interactive Audio-Only Telecommunications System) may be used, when indicated.

Before the changes for 2024, reporting unlisted codes for procedures that lacked specific CPT codes posed a challenge for many users, which was compounded by the conflicting coding guidance among medical specialties and payer policies. For example, in some cases, it was advised that when a procedure was performed for which there was no specific code and at the same session as another procedure, the unlisted code should be reported for the entire operative session. Other guidance stated to report both the specific code and the unlisted code. In other cases, when a specific Tier 1 or Tier 2 molecular pathology code was available to report a given diagnostic test that included other genes tested at the same time that were not specifically listed in that code's descriptor, standard CPT reporting protocol was to report the appropriate Tier 1 or Tier 2 molecular pathology code(s) and to separately report the unlisted code (eg, 81479) **once** for the balance of any other gene(s) not specified in the code descriptor. However, conflicting guidance from other sources stated to report the unlisted molecular pathology code for **each** gene not specifically named in the code descriptor. These types of variances existed within the same medical specialty or subspecialty and oftentimes changed back and forth over time, leading to inconsistencies and general confusion.

The new guidelines for reporting unlisted codes are intended to not only clarify and consolidate the coding guidance available but also to streamline, simplify, and standardize the reporting of unlisted procedures. To this end, instructional guidelines were added in many subsections of the Pathology and Laboratory section of the CPT code set to provide clear guidance on which unlisted code should be reported when a specific code is not available in that particular section or subsection. These new guidelines are as follows:

- **Pathology and Laboratory/Urinalysis:** Urinalysis procedures that are not specified in codes 81000-81050 should be reported using either the appropriate analyte-specific code in the Chemistry subsection (82009-84830) or code 81099, Unlisted urinalysis procedure, if an analyte-specific code is not otherwise available.
- **Pathology and Laboratory/Chemistry:** Procedures whose analytes are not specified in the Chemistry subsection (82009-84830), in either an analyte-specific code or method-specific code, should be reported using code 84999, Unlisted chemistry procedure.
- **Pathology and Laboratory/Hematology and Coagulation/Immunology:** Immunology analytes/procedures that are not specified in codes 86015-86835, and that are not in the Chemistry subsection (82009-84830), should be reported using code 86849, Unlisted immunology procedure.
- **Pathology and Laboratory/Transfusion Medicine:** Transfusion medicine analytes/procedures that are not specified in codes 86850-86985, and that are not in the Chemistry (82009-84830) or Immunology (86015-86835) subsections, should be reported using code 86999, Unlisted transfusion medicine procedure.
- **Pathology and Laboratory/Microbiology:** Microbiology analytes/procedures that are not specified in code 87003-87912, and that are not in the Chemistry (82009-84830) or Immunology (86015-86835) subsections, should be reported using code 87999, Unlisted microbiology procedure.
- **Pathology and Laboratory/Anatomic Pathology/Postmortem Examination:** Postmortem examination procedures that are not specified in codes 88000-88045 should be reported using code 88099, Unlisted necropsy (autopsy) procedure.
- **Pathology and Laboratory/Cytopathology:** Cytopathology procedures that are not specified in codes 88104-88189 should be reported using code 88199, Unlisted cytopathology procedure.
- **Pathology and Laboratory/Cytogenetic Studies:** Cytogenetic study procedures that are not specified in codes 88230-88291, and that are not in the Surgical Pathology subsection (88300-88388), should be reported using code 88299, Unlisted cytogenetic study.
- **Pathology and Laboratory/Surgical Pathology:** Surgical pathology procedures that are not specified in codes 88300-88388 should be reported using code 88399, Unlisted surgical pathology procedure.
- **Pathology and Laboratory/In Vivo (eg, Transcutaneous) Laboratory Procedures:** In vivo measurement procedures that are not specified in codes 88720-88741 should be reported using code 88749, Unlisted in vivo (eg, transcutaneous) laboratory service.
- **Pathology and Laboratory/Other Procedures:** Other procedures that are not specified in codes 89049-89230 or other subsections (Chemistry, Hematology and Coagulation, Immunology, Transfusion Medicine, Microbiology, Cytopathology) should be reported using code 89240, Unlisted miscellaneous pathology test.
- **Pathology and Laboratory/Reproductive Medicine Procedures:** Reproductive medicine procedures that are not specified in codes 89250-89356 should be reported using code 89398, Unlisted reproductive medicine laboratory procedure.

Prior to 2024, CPT convention guided users that unlisted codes should not be reported in multiple units or with modifiers appended because the procedure itself was unspecified, and it did not make sense to attempt to clarify the circumstances that would typically be identified using a modifier when appended to an otherwise unspecified procedure. This included modifiers 22, Increased Procedural Services, 50, Bilateral Procedure, 52, Reduced Services, and others. The changes made in the CPT 2024 code set now allow for an additional level of granularity because the changes standardize the reporting of unlisted codes across the entire code set.

Effective January 1, 2024, if multiple unlisted procedures are performed at the same session, each unlisted code may be reported. Furthermore, if an unlisted procedure is performed on more than one anatomical region (eg, on extremities, upper and/or lower, different spinal regions, etc.), then the unlisted procedure code may be reported in multiple units to account for each region or site treated. With the implementation of the new changes, modifiers may now be appended to denote different sides of the body (eg, LT, left side, RT, right side); an unlisted procedure performed bilaterally (eg, modifier 50); more than one unlisted procedure at the same session (eg, modifier 51 or 59); an unlisted procedure performed by two physicians (eg, modifier 62, Two Surgeons); and other appropriate modifiers to denote the special circumstance. As it was in the past, it is still essential to report unlisted procedure codes in accordance with individual third-party payer policies. Therefore, it may be necessary to provide comparison codes for the unlisted codes reported on claims submitted for payment.

