Category III Codes

CPT® Assistant.

January 2012; Volume 22: Issue 1

Question: A payer in my area says that assignment of a CPT Category III code status to a service indicates that the procedure or service is 'experimental/investigational' and as such is not eligible for coverage. They broadly deny coverage for all CPT Category III codes on this basis. Is it correct to say that the assignment of a CPT Category III code to a procedure or service means that it is xperimental/investigational and ineligible for coverage and payment or would it be more appropriate for the insurer to view all of the available evidence and make an independent assessment of whether the particular procedure or service should be covered and paid for?

Answer: The assignment of a Category III code to a service does not indicate that it is investigational, but only that the service or technology is new and is being tracked for data collection. The Center for Medicare and Medicaid Services (CMS) stated, in the Final Rule for the 2002 Medicare Physician Fee Schedule (Federal Register, November 1, 2001), that Category III codes 'will serve a useful purpose.' Subsequently, in the Final Rule for the 2004 Medicare Physician Fee Schedule (Federal Register, November 7, 2003) , CMS supported local coverage determination, but would create national payment policies and determine national payment amounts for CPT Category III tracking codes when there is a significant programmatic need to do so. CPT Category III codes are effectively more specific, more functional versions of unlisted codes which many payers cover with appropriate documentation.

CPT coding guidelines indicate that, when available, Category III codes must be used to report a procedure or service in lieu of unlisted Category I CPT codes. The data collected through the use of CPT Category III codes are vital to the evaluation of health care delivery and the formation of public and private health care policy.

Also, as indicated in the online CPT Process Booklet:
How a Code Becomes a Code (http://www.ama-assn.org /go/cpt-process) it is noted that:
'Category III CPT codes are not referred to the AMA/Specialty RVS Update Committee (RUC) for valuation because no relative value units (RVUs) will be assigned. Payment for these services/procedures is based on the policies of payers and local Medicare Carriers... Since Category III codes are part of the CPT code set, all health care payers must be able to accept Category III codes into their systems to comply with the standards for transactions and code sets under HIPAA.'

Question: What is the appropriate CPT code to report a minimally invasive lumbar decompression (MILD) procedure: code 22899 or code 64999?

Answer: Effective July 1, 2011, two codes are reportable for the MILD procedure depending on the anatomical area involved. Code 0274T, Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic, and code 0275T, Percutaneous laminotomy/laminectomy (interlaminar approach) for de-compression of neural elements, (with or without liga-mentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar. It is not appropriate to report either of the unlisted codes (22899 or 64999) after the implementation date of July 1, 2011. For more information see the AMA Category III code web site at www.ama-assn.org/resources/doc/cpt
/cptcat3codes.pdf, lists.

