CPT Category III Codes Cover New, Emerging Technologies: New Codes Developed to Address Issues in Light of HIPAA

by Michael Beebe, MS

In 1998, the American Medical Association (AMA) initiated the CPT-5 Project. This project was a broad-based and comprehensive effort to make needed and practical enhancements to the CPT code set that would address challenges presented by emerging user needs and HIPAA. One of the initiatives that emerged from the CPT-5 Project was the establishment of CPT category III codes for new and emerging technologies.

This article will discuss the rationale behind CPT category III codes, explain the intentions of the CPT Editorial Panel for applying these codes, and describe the structure of these codes.

A Step Toward Standardization

By developing CPT category III codes, the AMA and the CPT Editorial Panel attempted to resolve or alleviate three issues associated with the use of CPT codes in the expanded, national context of HIPAA: the elimination of local codes under HIPAA, the perceived slowness of the CPT editorial process, and the expanded use of administrative data for research purposes.

One of the initiatives of the CPT-5 Project was an attempt to prepare the CPT code set for the elimination of local codes. As anyone familiar with HIPAA knows, the code set standard requirement will eliminate the use of local, non-standard codes by the implementation date.[1] This is an important step toward the standardization of national healthcare information. It will support patient care by facilitating data collection and communication among healthcare professionals and will assist physicians and other healthcare professionals by simplifying the number of codes used for payment purposes.

Despite these benefits, many public and private payers regularly use local codes and need assistance to meet national standards. As part of this effort, the AMA conducted a survey of private payers to determine why they develop local codes and to capture a set of these codes for possible inclusion in CPT. Survey results indicated that payers use local codes for many reasons including data collection, new technologies, screening/counseling services, and non-physician provider services.

The use of local codes to describe new technologies was quite prevalent among private payers. This occurred typically in situations where the plan was collecting data to develop formal coverage policies and where there was no specific CPT code to describe the new technology. The lack of CPT codes for new and emerging technologies was, in the estimate of private payers, caused by the slowness of the CPT editorial process.

Creating New Codes

The CPT Editorial Panel functions as a deliberative peer review body. The panel employs well-established, publicized, and documented procedures.[2] These procedures are designed to include as many relevant stakeholders as is feasible and to ensure the panel has the appropriate information on which to base its decisions. While the panel's procedures are appropriate for meeting its editorial responsibilities, they do have the effect of lengthening the code development process.

Among the editorial panel requirements that can delay creation of codes for new technology is the need to produce evidence and frequency of use before a code is issued. The development of temporary tracking codes issued by the panel would alleviate this problem and allow data to be collected on new technologies. In addition, the Centers for Medicare & Medicaid Services (CMS) updates the Medicare fee schedule yearly, which, in conjunction with the time required for publishing CPT books, has the effect of further impeding the development of new CPT codes. The development of a new set of CPT codes

that would not be subject to Medicare updates or book publishing timelines would assist in expediting the delivery of new CPT codes that could be used to track new technologies.

The need for tracking services involving new technology is driven by the expanded use of administrative healthcare data for research purposes. The availability and relatively low cost of administrative data has stimulated its use for research. Health services research, epidemiological studies, and some performance measurement activities are often directed at populations of patients and require information about the demographics of a population, which can be found in the administrative record. In addition, technology assessment, an activity that is critically important in the evaluation of healthcare delivery and the formulation of public and private payment policy, can be conducted using administrative data.

CPT codes were problematic, however, for use in such studies, as the services and procedures being investigated usually represent new technologies. The use of unlisted CPT codes for new technologies obscures the ability to track a specific service. Therefore, much of the necessary information is not found in claims data for services coded with CPT. The development of CPT category III codes was intended to address the need for tracking codes to facilitate use of administrative data for research purposes.

Category III Structure

CPT category III codes do not conform to the usual requirements for CPT category I codes established by the editorial panel. For category I codes, the panel requires that the service/procedure be performed by many healthcare professionals in clinical practice in multiple locations and that FDA approval, as appropriate, has already been received. The nature of emerging technologies, services, and procedures is such that these requirements may not be met. The panel has established the following criteria for evaluating category III code requests, any one of which is deemed sufficient:

- a protocol for a study of procedures being performed
- support from the specialties that would use the procedure
- availability of US peer-reviewed literature
- descriptions of current US trials outlining the efficacy of the procedure

Services/procedures described by CPT category III codes make use of alphanumeric characters. These codes have “T” as the fifth character in the string, preceded by four digits. The CMS-maintained Healthcare Common Procedure Coding System (HCPCS) also uses five character alphanumeric codes, so the category III CPT codes should not present a problem for computer systems. Category III codes may or may not eventually receive a category I CPT code. In either case, a given category III code will be archived five years after its inception unless it is demonstrated that a temporary code is still needed.

Because CPT category III codes will be carrier or payer priced, they will not receive relative value recommendations from the AMA Specialty Society Relative Value System Update Committee (RUC). As a result, new category III codes are released semi-annually via the AMA/CPT Web site to expedite dissemination for reporting.[3]

The full set of temporary codes for emerging technology, services, and procedures are published annually in the CPT book. CPT category III codes are posted on the AMA/CPT Web site according to a very specific schedule of release dates and effective dates. To provide time for payers to incorporate new category III codes into their claims systems, the panel has instituted a six-month delay between release dates and effective dates.

Using Category III Codes

Category III codes are intended to facilitate the reporting of new and emerging services and technologies associated with these services. It is the intention of the CPT Editorial Panel that CPT category III codes should be eligible for payment and that, when available, category III codes must be used instead of unlisted codes.

The assignment of a CPT category III code to a service does not indicate that it is experimental or of limited utility, but only that the service or technology is new and is being tracked for data collection. In the final rule for the 2002 Medicare Physician Fee Schedule, CMS stated that it believed that category III codes “will serve a useful purpose” and that payment for the service is at the discretion of the carriers, but that the codes could be paid after they are entered into the computer systems.[4]

Local payment determination is reasonable for category III CPT codes. It is not reasonable to categorically deny payment for CPT category III codes, as they are effectively more specific and more functional versions of unlisted codes, which many payers cover with appropriate documentation.

Once payment policies are established for a category III code, the need for documentation will be minimized, as category III codes are associated with unique and specific descriptions of the service or procedure. Category III codes are part of the CPT code set, therefore all healthcare payers must be able to accept category III codes to comply with the standards for transactions and code sets under HIPAA.

The CPT Editorial Panel is excited about the development of CPT category III codes and optimistic that category III codes will enable data collection and research while assisting payers to comply with HIPAA's requirement to eliminate local codes. It may take users and payers time to become accustomed to category III codes, but the end result will be better data and more coherent payment policies.

CMS Proposes National Payment Policy

In the August 15, 2003, *Federal Register* (Vol. 68, no. 158), CMS proposed to create a national payment policy for CPT tracking codes. It stated, "We propose to create national payment policy and determine national payment amounts for CPT tracking codes when there is a significant programmatic need for us to do so." CMS stated that a need could arise, for example, if it receives requests from carrier medical directors that they establish such a national payment policy because of the carrier's inability to do so. At press time, no further updates had been made.

Don't Miss this BoK Home Health Coding Extra

Beginning October 1, 2003, home health agencies will see changes to the Outcome and Assessment Information Set (OASIS). Find out the details in "HIPAA Transaction Standards Force OASIS Changes for Home Health," by Prinny Rose Abraham, RHIT, CPHQ. This article is only available in the FORE Library: HIM Body of Knowledge (BoK).

Effective October 1, 2003, home health agencies will be able to report V codes in data field MO230 (primary diagnosis). E codes and V codes will be allowed in MO240 (secondary diagnoses). A new data field, MO245, has been created to report a case mix diagnosis if a V code has been reported in M0230 and it replaces a case mix diagnosis. It is imperative that agencies are familiar with these changes for proper reimbursement.

To obtain the article go to Communities of Practice at www.ahima.org, log in, and then click on the computer icon for HIM Body of Knowledge. You can select "advanced search" and search by article author or title.

Notes

1. For more information on HIPAA code set transactions, go to http://aspe.os.dhhs.gov/admnsimp/bannertx.htm.
2. For information on the CPT Editorial Panel process, visit the AMA Web site at www.ama-assn.org/ama/pub/category/3882.html.
3. A list of category III codes that have been released and a code release schedule is available on the AMA Web site at www.ama-assn.org/ama/pub/article/3885-4897.html.
4. *Federal Register* 66, no. 212, November 1, 2001; p. 55245-55294. Available at www.gpoaccess.gov.

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