



SOLVING CARRIER ISSUES: CATEGORY III & UNLISTED CODES



What are the CPT Code Categories?

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- **CPT Category I codes** are generally based upon the procedure being **consistent with contemporary medical practice** and being **performed by many physicians** in clinical practice in **multiple locations**
- **CPT Category II codes** are supplemental tracking codes that can be used for **performance measurement**
- **CPT Category III codes** are a set of **temporary codes** for **emerging technology, services, and procedures**
- **Unlisted codes** do not offer the opportunity for the collection of specific data. If a Category III code is available, this code should be reported instead of an unlisted code.



Category I Criteria

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A proposal for a new or revised **Category I code** must satisfy **all** of the following criteria:

- All devices and drugs necessary for performance of the procedure or service have **FDA clearance** or approval when such is required for performance of the procedure or service;
- Is **performed by many physicians** or other qualified health care professionals across the US
- The procedure or service is performed with **frequency consistent with the intended clinical use** (i.e., a service for a common condition should have high volume, whereas a service commonly performed for a rare condition may have low volume);
- The procedure or service is **consistent with current medical practice**; and
- The clinical efficacy of the procedure or service is **documented in literature that meets the requirements** set forth in the CPT code change application

Category III Criteria

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The procedure or service for a **Category III code** is currently or recently performed in humans; **and**

At least one of the following additional criteria has been met:

- The application is **supported** by at least one CPT or HCPAC advisor representing practitioners who would use this procedure or service; **or**
- The actual or potential clinical efficacy of the specific procedure or service is **supported by peer reviewed literature**, which is available in English for examination by the CPT Editorial Panel; **or**
- There is (a) **at least one Institutional Review Board–approved protocol of a study** of the procedure or service being performed; (b) a description of a current and ongoing **United States** trial outlining the efficacy of the procedure or service; or (c) other evidence of evolving clinical utilization.

Category III Codes

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- A set of **temporary** codes for **emerging technology, services, procedures**, and service paradigms
- Allow **data collection** for these services/procedures
 - Use of **unlisted codes does not offer the opportunity for the collection of specific data**
- If a Category III code is available, this code **should be reported instead of a Category I unlisted code**
 - critically important in the tracking of new procedures and technologies
 - allows physicians, insurers, health services researchers, and health policy experts to identify emerging technology, services, procedures, and service paradigms for **clinical efficacy, utilization and outcomes**

Category III Codes

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- Have an alpha character as the 5th character in the string (i.e., **four digits followed by the letter T**)
- Not intended to reflect the placement of the code in the Category I section of CPT nomenclature
- **May or may not eventually receive a Category I CPT code**
- As with the CPT unlisted codes, it is **not appropriate to append any modifier** to the CPT Category III codes
 - this is due to the fact that Category III code **work values have not been established**
 - without work values, the codes cannot be recommended to the Centers for Medicare & Medicaid Services (CMS) for addition to the Medicare Physician Fee Schedule

Category III Codes-examples

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- 0406T Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant
 - 0407T with biopsy, polypectomy or debridement
- (Do not report 0406T, 0407T in conjunction with 31200, 31201, 31205, 31231, 31237, 31240, 31254, 31255, 31288, 31290 when performed on the same side)
- (Do not report 0407T in conjunction with 0406T if performed on the same side)

Unlisted Codes

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- Guidance from CPT Professional 2019:

*“Select the name of the procedure or service that accurately identifies the service performed. Do **not select** a CPT code that **merely approximates** the service provided. **If no such specific code exists, then report the service using the appropriate unlisted procedure or service code.**”*



Unlisted Codes

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- **17999** Unlisted procedure, skin, mucous membrane and subcutaneous tissue
- **21299** Unlisted craniofacial and maxillofacial procedure
- **21899** Unlisted procedure, neck or thorax
- **30999** Unlisted procedure, nose
- **31299** Unlisted procedure, accessory sinuses
- **31599** Unlisted procedure, larynx
- **40799** Unlisted procedure, lips
- **40899** Unlisted procedure, vestibule of mouth
- **41599** Unlisted procedure, tongue, floor of mouth
- **41899** Unlisted procedure, dentoalveolar structures
- **42299** Unlisted procedure, palate, uvula
- **42699** Unlisted procedure, salivary glands or ducts
- **42999** Unlisted procedure, pharynx, adenoids, or tonsils

Each organ system and/or body area section of the CPT manual has an unlisted code that corresponds to an unlisted procedure in that organ system and/or body area



Unlisted Codes

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- **43289** Unlisted laparoscopy procedure, esophagus
- **43499** Unlisted procedure, esophagus
- **60699** Unlisted procedure, endocrine system
- **64999** Unlisted procedure, nervous system
- **67599** Unlisted procedure, orbit
- **67999** Unlisted procedure, eyelids
- **68399** Unlisted procedure, conjunctiva
- **68899** Unlisted procedure, lacrimal system
- **69399** Unlisted procedure, external ear
- **69799** Unlisted procedure, middle ear
- **69949** Unlisted procedure, inner ear
- **69979** Unlisted procedure, temporal bone, middle fossa approach

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Coding Resources

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Proper Coding Resources

- AAO/HNS Resources
(www.entnet.org/content/coding-corner)
- AMA Resources (CPT[®] Assistant, CPT Professional[®], RUC Database,[®] CodeManager[®])
(<https://commerce.ama-assn.org/store/ui>)
- EncoderPro[®]
(<https://www.encoderpro.com/epr/>)
- NCCI Edits
(www.cms.gov)



Coding Resources

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Improper Coding Resources

- Industry vendor representatives
- Doctors' Lounge
- Bankers

Unlisted and Category III Codes

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Reimbursement

- Use of these codes typically requires **more steps before and after** the procedure than reporting a procedure that has a specific Category I CPT code
- To lessen the chance of payment denial for elective cases, it is **best** to obtain **prior authorization** in writing from the payor before performing an unlisted procedure
- Most payors have a **prior authorization form** that allows the surgeon to **describe the planned procedure and the medical necessity** of the operation

Unlisted and Category III Codes

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If no prior authorization...

- If an unlisted procedure is performed without prior authorization (for example, an urgent operation or unanticipated intraoperative procedure), include:
 - **operative report**
 - supporting information outlining the decision-making process and the **medical rationale** for performing the operation.
- For Medicare patients, this documentation should be submitted to the appropriate Medicare Administrative Contractor (MAC)
- **Individual payors may have processes** in place for submitting claims for unlisted codes
- It is important to **be familiar** with your top payors' specific process to help expedite the claim

Unlisted and Category III Codes

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Documentation

- **Describe all of the work** in the operative report
- Make sure that **justification** for the procedure and all diagnoses are on clinic note and operative report
- Always put the **description** of the unlisted procedure **in the system**. For example, if you list CPT Code 17999 on line 24. D., include “Unlisted procedure, skin, mucous membrane and subcutaneous tissue” on line 19.
 - (On the claim form it will/should populate the Additional Claim Information field. This field is used to identify additional information about the patient’s condition or the claim.)

Unlisted Codes

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Billing Caveats

- For CMS use the **Form 1500** with **concise description**
 - Additional **attachments** supporting Line 19

Unlisted Codes

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Billing Caveats

- Some insurers require that you **file electronically** first
- They will then send a medical request with a **bar code**; this is when we **attach the medical records and op note**. This is then faxed and mailed back to them
- They will use the **op note** to determine the amount of payment-to-be complete
- Use a **cover letter**

Unlisted and Category III Codes

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Cover Letter

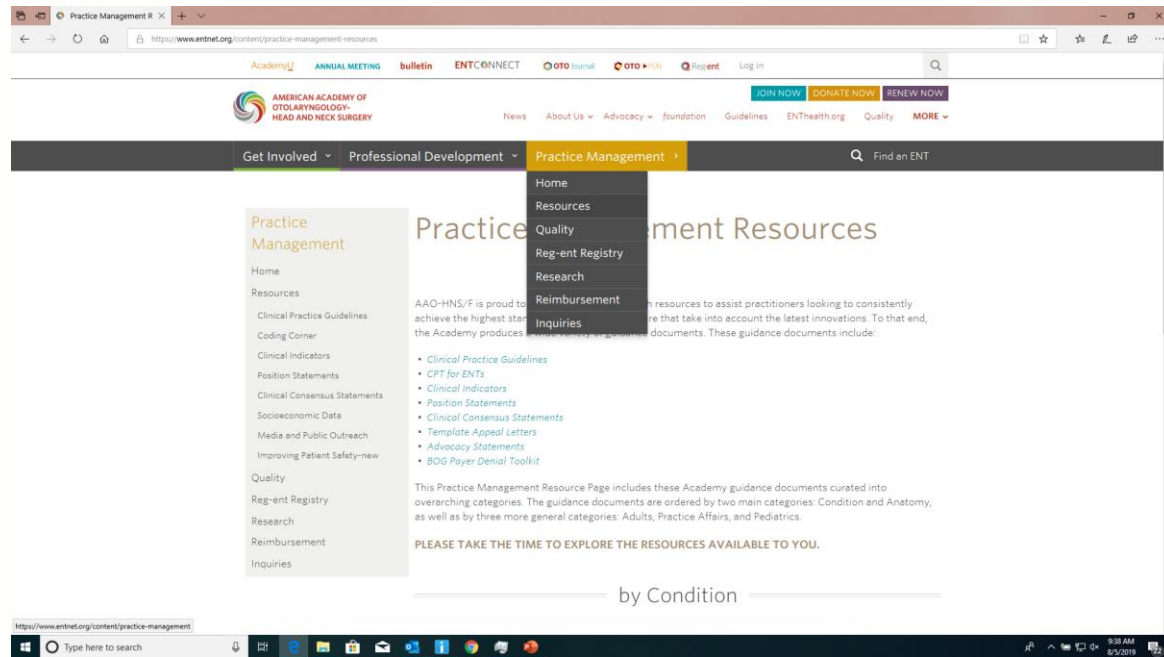
- Use a cover letter that *briefly, professionally, kindly, and succinctly* states the **necessity** of why you performed the procedure and the **standards** for doing so
- Be **respectful**
- Note **specific criteria**
- Make a **specific case**/demand as to why you should get paid x.
- **Compare to existing** code with **similar work** and define similarities
- Send **supporting data**

Unlisted and Category III Codes

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Supporting Data-Resources

- <http://www.entnet.org/content/practice-management-resources>
- [*Clinical Practice Guidelines*](#)
- [*Clinical Indicators*](#)
- [*Position Statements*](#)
- [*Clinical Consensus Statements*](#)
- [*Advocacy Statements*](#)



Unlisted and Category III Codes

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Fee-setting

- For **CMS**, your charge for the unlisted procedure is included in Item **24.F** of the **1500 claim form**
- For any payer, support your charge

The image shows a standard Health Insurance Claim Form (NUCC 1500) with various fields for patient and insurer information, including name, address, date of birth, and policy details. It includes a QR code in the top left corner and a 'PLEASE PRINT OR TYPE' instruction at the bottom. The form is divided into sections for patient information, insurer information, and a table for procedure charges. The table has columns for date of service, procedure code, and amount paid. The form is titled 'HEALTH INSURANCE CLAIM FORM' and 'APPROVED BY NATIONAL LABORERS CLAIM COMMITTEE (NUCC) 05/12'.

Unlisted and Category III Codes

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Fee-setting - Support your charge

- Choose a **comparison code that is similar** to the unlisted procedure performed
- This code should represent surgery on the **same body area**
- For example, prior to endoscopic Zenker's code, you may choose the CPT code for open diverticulectomy as your comparison code for a endoscopic diverticulectomy. (Possibly with reduced services modifier)
- Again, each organ system and/or body area section of the CPT manual has an unlisted code that corresponds to an unlisted procedure in that organ system and/or body area

Unlisted and Category III Codes

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Fee-setting - Support your charge

- List **two or three factors** that make the unlisted procedure the **same work**, or more or less difficult than the comparison code.
- For example, your letter could indicate that the unlisted procedure required a different operative approach and approximately 30 minutes of additional operative time than the comparison CPT code.

Unlisted and Category III Codes

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Fee-setting - Support your charge

- **Indicate the difference in work** between the unlisted or Category III procedure and the comparison code using a percentage.
- For example, you may estimate that the procedure required 50 percent more time for exposure, exploration, and closure than the comparison CPT code.
 - the **percentage** indicated in this step is **critically important**; although the payor will adjust up or down from its fee schedule, not the physician's charge.

Unlisted and Category III Codes

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Fee-setting - Support your charge

- Indicate the normal fee for the comparison CPT code and indicate the fee for the unlisted CPT code based on the percentage of more or less work required and documented in your letter.
- For example, you may indicate that your normal fee for comparison CPT code is \$2,000, and therefore you have set your fee for the unlisted procedure at \$3,000 because it required 50 percent more time for exposure and resection.

Conclusion - Fee Setting

- When reporting an unlisted or Category III code to describe a procedure or service, submit **supporting documentation** along with the claim to provide an adequate **description of the nature, extent, and need for the procedure** and the **time, effort, and equipment necessary** to provide the service.
- For more detailed information about submitting an unlisted code to Medicare, see **Chapter 26 of the Medicare Claims Processing Manual**.[†]

Appeals

- **No complaints, no emotion**
- **Stick to the facts**
- **Be respectful**
- Reference specifically the **carrier's criteria** and how **your patient satisfied** it.
- Be **direct and explicit** in what you are asking them to pay for and **why**
- Compare to existing code with similar work and define similarities
- Send **supporting data**

What's Left?

- Did you contact your **county and state medical society**?
 - Existing relationships with carrier leadership
 - Coding/appeal advocates
- Determine the scope of the issue. Other specialties affected?
- Does your **ENT society/specialty society** have coding/payment resources/experts (e.g. NYSSO)?
- **ENTConnect** outreach to peers
- **Additional Academy resources**