Category I, II and III Code Designations

Current Procedural Terminology (CPT) coding, the national standard code set for billing of procedures/services to Medicare and other third-party payers, currently recognizes three levels of codes designated as Category I, Category II and Category III. The following is a detailed explanation of the Category I, II and III codes under CPT and how they relate to the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes.

Background

The CPT system was chosen as the national standard code set by the Health Care Financing Administration (HCFA—now known as the Centers for Medicare and Medicaid Services, or CMS) in August 2000. The creation of a single coding system was mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which cited shortcomings in the CPT system. To ensure that CPT would be chosen as the national standard, the CPT 5 Project was initiated to create uniform instruction and interpretation and to guarantee the correct application of coding. Recommendations of the CPT 5 Project have been implemented gradually since 1998, with completion of the recommended changes to be recognized in 2003. As part of the CPT 5 Project, Category I, II and III codes were recommended and approved by the CPT Editorial Panel.

Category I

CPT Category I codes are the familiar five-digit codes that describe a procedure or service (e.g., 71010 – single view chest). To be considered as a Category I code, CPT requires that the service or procedure be widely accepted in the medical community, that Food and Drug Administration approval of a drug or device associated with the procedure be documented or imminent within a given CPT cycle and that the service or procedure has proven clinical efficacy as evidenced by many peer-reviewed journal articles. These codes are also known as HCPCS Level I codes. The Category I (HCPCS Level I) codes are created and maintained by the CPT Editorial Panel. Once a procedure is approved as a Category I code, the code is referred to the Relative Value Update Committee (RUC) for valuation. The relative value unit (RVU) is determined by the amount of work, practice expense and malpractice expense associated with the procedure. The RUC makes a recommendation to CMS on physician work and practice expense inputs. It is CMS that makes the final determination on the assignment of RVUs. Medicare payment is then determined by multiplying these RVUs by a conversion factor. The RVUs assigned are published yearly in the Federal Register in the "Medicare Physician Fee Schedule."

Category II

The CPT Category II codes are "optional" performance measurement codes with alphanumerical code designations (e.g., 1234F). These codes will be used to track the performance of certain services and/or test results that contribute to quality patient care. Examples of Category II codes are services that are typically included in evaluation and management (e/m) services or that are a component of another service. These codes were established to decrease the need to manually audit charts for this information. The reporting of a Category II code is optional and is not required for correct coding. Because Category II codes are used for informational purposes only, no payment will be associated with these codes. To date, no Category II codes have been assigned.
Note that CPT Category II performance measurement codes have no relationship to the HCPCS Level II codes developed by CMS for billing Medicare. The HCPCS Level II codes describe medical services and supplies not contained in CPT. For example, A4641 (supply of radiopharmaceutical) and A4644 (supply of low osmolar contrast material) are codes used for the separate billing of supplies. HCPCS Level II codes also are assigned to clarify Medicare coverage policy. For example, although CPT codes have been established to define PET myocardial perfusion imaging procedures (78491-78492), "G" codes G0030-G0047 have been established by CMS to further differentiate the types of PET procedures covered by Medicare.

**Category III**

Creation of the CPT Category III codes was necessitated by HIPAA's elimination of the HCPCS Level III codes (also known as local codes). The HCPCS Level III codes were developed by individual carriers to identify those procedures not yet identified by an HCPCS Level I or II code. Whereas the Category I codes pertain to clinically recognized and generally accepted services, the Category III codes are used to designate newly emerging technologies and to track their usage in the medical community. When a Category III code is assigned, it must be used in place of the unlisted procedure code. The use of a Category III code, unlike the unlisted procedure code, permits data collection to substantiate widespread usage of the specific procedure/service that is in the FDA approval process.

Similar to the CPT Category II codes, Category III codes will be identified by an alphanumeric code (e.g., 0007T). Category III codes, if covered, are reimbursable under payer policy (i.e., reimbursement is carrier-determined).

Recognizing the need to have CPT III codes available for use as soon as possible, the CPT Editorial Panel approved the early release of CPT III codes. These codes are available through the American Medical Association's Web site, which is updated semiannually in January and July. These codes are then published in the next yearly update of the CPT manual. Please reference the sidebar on carotid stent for an example of a current CPT III code.

The Category III codes are temporary codes and will be updated to a Category I code only if they meet the Category I requirements as described above. If a Category III code is not upgraded to a Category I code within five years, it will be archived unless a continued need for the code is demonstrated.

**Updates to Procedure Codes**

Newly established CPT codes are published yearly in the CPT manual and are effective Jan. 1 of each year. The CPT 2002 manual will contain a listing of the Category I, II and III codes assigned. The Category II and III codes will be listed in a separate section of the CPT manual following the Medicine section.

Medicare's HCPCS Level II codes are published in the Federal Register, "Medicare Physician Fee Schedule," and are updated throughout the year in Program Memoranda sent to carriers, intermediaries and providers.

A summary of the new/revised radiology and radiation oncology CPT Category I and III codes for 2002 will be featured in a future issue of the ACR Bulletin after the codes are released for publication.
Members with questions regarding this article may contact the economics and health policy department at (800) 227-5463, ext. 4584, or fax their questions to (703) 391-1757.

Carotid Stent Placement CPT III Codes Established

Three new Category III codes were created and effective as of July 1, 2001, to identify carotid stent placement.

CPT III Code Descriptor

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0005</td>
<td>Transcatheter placement of extracranial cerebrovascular artery stent(s), percutaneous; initial vessel</td>
</tr>
<tr>
<td>+0006T</td>
<td>Each additional vessel (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0007T</td>
<td>Transcatheter placement of extracranial cerebrovascular artery stent(s), percutaneous, radiological supervision and interpretation, each vessel</td>
</tr>
</tbody>
</table>

Note that percutaneous transluminal angioplasty (PTA) of the carotid artery, when provided solely for the purpose of carotid artery dilation concurrent with carotid stent placement, is covered by Medicare as of July 1, 2001 (Program Memorandum AB-01-74). PTA is covered only if it is part of a clinical trial that has a Category B investigational device exemption (IDE). PTA of the carotid artery for treating obstructive lesions outside of an appropriate Category B IDE clinical trial and PTA of the vertebral and cerebral arteries remain as noncovered procedures.

CPT Category I Code Assigned for Computer-aided Detection

The CPT Editorial Panel has approved a five-digit CPT code for Computer-aided Detection (CAD) for inclusion in the CPT 2002 manual. As of Jan. 1, 2002, a new CPT Category I add-on code will need to be assigned in addition to 76092 (screening mammography) to describe the additional work required when film is converted to digital images, and computer analysis is used for interpretation. This new code will be valued by the Relative Value Update Committee (RUC) in September, and the RVUs will be included in the 2002 Medicare Physician Fee Schedule.

The establishment of this new Category I code will replace the currently used HCPCS code G0203 (screening mammography, film to digital), which will not be valid after Dec. 31, 2001.

Co-surgeon Modifier Approved for Use with Endovascular Abdominal Aortic Aneurysm

As of Oct. 1, 2001, the Centers for Medicare and Medicaid Services (CMS) has instructed Medicare carriers to accept the co-surgeon modifier (-62) when used with the endovascular repair of abdominal aortic aneurysm codes (34800-34832) and with percutaneous thrombectomy for arteriovenous fistula (36870). This means that when these procedures are done by a team of two physicians both will be
permitted to code 348XX –62 or 36870-62 and get paid one-half of 125 percent of the allowed amount. Transmittal #AB-01-108 was issued Aug. 3, 2001, with an effective date of Jan. 1, 2001.

Carrier medical directors have not been instructed to check their claim systems and retrospectively pay for procedures performed between Jan. 1, 2001 through Sept. 30, 2001. Radiology practices will have to resubmit past claims for consideration of claims adjustment.