Category III CPT Codes

Medicare Advantage Medical Policy #MA-120
Original Effective Date: 09/01/2025
Current Effective Date: 09/01/2025

Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

In the absence of a National Coverage Determination (NCD), Novitas Local Coverage Determination (LCD), or Blue Advantage medical policy, the Health Plan considers all services and procedures listed in the current and future Category III CPT Code list to be **investigational.***

Current Category III CPT Codes include, but are not limited to, the following:

CPT Code	Description
0948T	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system with interim analysis, review and report(s) by a physician or other qualified health care professional
0949T	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system, remote data acquisition(s), receipt of transmissions, technician review, technical support, and distribution of results
0950T	Ablation of benign prostate tissue, transrectal, with high intensity–focused ultrasound (HIFU), including ultrasound guidance
0951T	Totally implantable active middle ear hearing implant; initial placement, including mastoidectomy, placement of and attachment to sound processor
0952T	Totally implantable active middle ear hearing implant; revision or replacement, with mastoidectomy and replacement of sound processor
0953T	Totally implantable active middle ear hearing implant; revision or replacement, without mastoidectomy and replacement of sound processor
0954T	Totally implantable active middle ear hearing implant; replacement of sound processor only, with attachment to existing transducers
0955T	Totally implantable active middle ear hearing implant; removal, including removal of sound processor and all implant components
0956T	Partial craniectomy, channel creation, and tunneling of electrode for sub-scalp implantation of an electrode array, receiver, and telemetry unit for continuous bilateral electroencephalography monitoring system, including imaging guidance
0957T	Revision of sub-scalp implanted electrode array, receiver, and telemetry unit for electrode, when required, including imaging guidance

0958T	Removal of sub-scalp implanted electrode array, receiver, and telemetry unit for continuous bilateral electroencephalography monitoring system, including imaging guidance
0959T	Removal or replacement of magnet from coil assembly that is connected to continuous bilateral electroencephalography monitoring system, including imaging guidance
0960T	Replacement of sub-scalp implanted electrode array, receiver, and telemetry unit with tunneling of electrode for continuous bilateral electroencephalography monitoring system, including imaging guidance
0961T	Shortwave infrared radiation imaging, surgical pathology specimen, to assist gross examination for lymph node localization in fibroadipose tissue, per specimen (List separately in addition to code for primary procedure)
0962T	Assistive algorithmic analysis of acoustic and electrocardiogram recording for detection of cardiac dysfunction (eg, reduced ejection fraction, cardiac murmurs, atrial fibrillation), with review and interpretation by a physician or other qualified health care professional
0964T	Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; single arch, without mandibular advancement mechanism
0965T	Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; dual arch, with additional mandibular advancement, non-fixed hinge mechanism
0966T	Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; dual arch, with additional mandibular advancement, fixed hinge mechanism
0967T	Transanal insertion of endoluminal temporary colorectal anastomosis protection device, including vacuum anchoring component and flexible sheath connected to external vacuum source and monitoring system
0968T	Insertion or replacement of epicranial neurostimulator system, including electrode array and pulse generator, with connection to electrode array
0969T	Removal of epicranial neurostimulator system
0970T	Ablation, benign breast tumor (eg, fibroadenoma), percutaneous, laser, including imaging guidance when performed, each tumor
0971T	Ablation, malignant breast tumor(s), percutaneous, laser, including imaging guidance when performed, unilateral
0972T	Assistive algorithmic classification of burn healing (ie, healing or nonhealing) by noninvasive multispectral imaging, including system set-up and acquisition, selection, and transmission of images, with automated generation of report
0973T	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, trunk, arms, legs; first 100 sq cm
0974T	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including

	patient monitoring, trunk, arms, legs; each additional 100 sq cm (List separately in addition to code for primary procedure)
0975T	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, scalp, neck, hands, feet, and/or multiple digits; first 100 sq cm
0976T	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, scalp, neck, hands, feet, and/or multiple digits; each additional 100 sq cm (List separately in addition to code for primary procedure)
0977T	Upper gastrointestinal blood detection, sensor capsule, with interpretation and report
0978T	Submucosal cryolysis therapy; soft palate, base of tongue, and lingual tonsil
0979T	Submucosal cryolysis therapy; soft palate only
0980T	Submucosal cryolysis therapy; base of tongue, and lingual tonsil only
0981T	Transcatheter implantation of wireless inferior vena cava sensor for long-term hemodynamic monitoring, including deployment of the sensor, radiological supervision and interpretation, right heart catheterization, and inferior vena cava venography, when performed
0982T	Remote monitoring of implantable inferior vena cava pressure sensor, physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial set-up and patient education on use of equipment
0983T	Remote monitoring of an implanted inferior vena cava sensor for up to 30 days, including at least weekly downloads of inferior vena cava area recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional
0984T	Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; initial vessel (List separately in addition to code for primary procedure)
0985T	Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure)
0986T	Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; initial vessel (List separately in addition to code for primary procedure)
0987T	Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure)

Background/Overview

Current Procedural Terminology (CPT) Codes

The American Medical Association (AMA) develops (CPT) Category III codes defined as a set of temporary codes for emerging technology, services, procedures, and service paradigms. Category III codes allow data collection for these services/procedures. If a Category III code is available, this code must be reported instead of a Category I unlisted code. The use of theses codes allows physicians and other qualified health care professionals, insurers, health services researchers, and health policy experts to identify emerging technology, services, procedures, and service paradigms for clinical efficacy, utilization and outcomes. The inclusion of a service or procedure as a category III code does not constitute a finding of support, or lack thereof, with regard to clinical efficacy, safety, applicability to clinical practice, or payer coverage. Theses codes may not conform to the usual requirements for CPT Category I codes established by the AMA.

For Category I codes, the AMA requires that the service/procedure be performed by many health care professionals in clinical practice in multiple locations and that FDA approval, as appropriate, has already been received. The nature of emerging technology, services, procedures, and service paradigms is such that these requirements may not be met. For these reasons, temporary codes for emerging technology, services, procedures, and service paradigms have been placed in a separate section of the CPT code set and the codes are differentiated from Category I CPT codes by the use of alphanumeric characters, (ie, four digits followed by the letter T).

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

Section 1862(a)(1)(A) of the Social Security Act (SSA) is the statutory basis for denying payment for types of care, items, services, and procedures, not excluded by any other statutory clause while meeting all technical requirements for coverage, that are determined to be any of the following:

- Not generally accepted by the medical community as safe and effective in the setting and for the condition for which it is used;
- Not proven safe and effective based on peer review or scientific literature;
- Experimental;
- Not medically necessary for a particular patient;
- Furnished at a level, duration, or frequency that is not medically appropriate;
- Not furnished in accordance with accepted standards of medical practice; or
- Not furnished in a setting appropriate to the patient's medical needs and condition.

Items and services must be established as safe and effective to be considered medically necessary. That is, the items and services must be:

- Consistent with the symptoms of diagnosis of the illness or injury under treatment;
- Necessary for, and consistent with, generally accepted professional medical standards of care (e.g., not experimental);
- Not furnished primarily for the convenience of the patient or of the provider or supplier; and
- Furnished at the most appropriate level of care that can be provided safely and effectively to the patient.

Medical devices that are not approved for marketing by the Food and Drug Administration (FDA) are considered investigational by Medicare and are not considered reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Program payment, therefore, may not be made for medical procedures and services performed using devices that have not been approved for marketing by the FDA or for those not included in an FDA-approved investigational device exemption (IDE) trial.

References

1. Centers for Medicare & Medicaid Services (CMS). Medicare Coverage Database. National coverage determination (NCD) Search. Local Coverage Determination (LCD): Category III CPT® Codes (L34370, L33392, L34995). Accessed at: https://www.cms.gov/medicare-coverage-database/new- search/search.aspx
2. American Medical Association (AMA). Category III Codes. Accessed at: https://www.ama-assn.org/practice-management/category-iii-codes
3. Novitas Solutions. Non-covered services. Accessed at https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00027359.

Policy History

Original Effective Date: 09/01/2025
Current Effective Date: 09/01/2025
06/17/2025 Utilization Management Committee review/approval. New policy.
07/15/2025 Coding update.
Next Scheduled Review Date: 06/2026

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and

whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or

B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
    1. Consultation with technology evaluation center(s);
    2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
    3. Reference to federal regulations.

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NOTICE: If the Patient's health insurance contract contains language that differs from the Health Plan's Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

Medicare Advantage Members
Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-benehelp.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.

InterQual®
Interqual® is utilized as a source of medical evidence to support medical necessity and level of care decisions. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider. InterQual® criteria are clinically based on best practice, clinical data, and medical literature. The criteria are updated continually and released annually. InterQual® criteria are a first-level screening tool to assist in determining if the proposed services are clinically indicated and provided in the appropriate level or whether further evaluation is required. The utilization review staff does the first-level screening. If the criteria are met, the case is approved; if the criteria are not met, the case is referred to the medical director.