

## Category III Codes

Policy Number: EXPERIMENTAL 004.2  
Effective Date: May 1, 2023

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### Related Policy

- [Omnibus Codes](#)

## Coverage Rationale

See [Benefit Considerations](#)

Category III codes are considered experimental, investigational, or unproven and not medically necessary due to insufficient evidence of efficacy. Refer to the *Category III CPT Codes List* in the [Applicable Codes](#) section for specific information surrounding a Category III code.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

### CPT Codes

[Category III CPT Codes List](#)

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## Description of Services

Current Procedural Terminology (CPT®) Category III codes are a set of temporary codes that allow physicians and other qualified health care professionals to identify and submit for emerging technology, services, and procedures for clinical efficacy, utilization and outcomes. The assignment of these codes from the AMA offers the opportunity for specific data collection unlike unlisted codes, which requires specific documentation describing the procedure.

Unlike Category I CPT® codes, these do not necessitate FDA approval and therefore have been placed in a separate section of the CPT book. Per the AMA, “the inclusion of a service or procedure in this section does not constitute a finding of support, or lack thereof, with regard to clinical efficacy, safety, applicability to clinical practice, or payer coverage.”

Category III codes may or may not eventually receive a Category I code. “In general, a given Category III code will be archived five years from the date of initial publication or extension unless a modification of the archival date is specifically noted at the time of a revision or change to a code”. (AMA, 2022)

## Benefit Considerations

Services that are not Medically Necessary; Experimental or Investigational; or Unproven are excluded from coverage on most plans. The fact that such services may be the only available treatment(s) for a particular condition will not result in benefits if the service is considered to be not Medically Necessary; Experimental or Investigational; or Unproven in the treatment of that particular condition. This exclusion does not apply to certain Covered Health Care Services provided during a clinical trial for which benefits may be provided under the benefit plan document.

## References

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [2023T0644A]

American Medical Association (AMA). Current Procedural Terminology (CPT®) book. Chicago, IL. 2022.

UnitedHealthcare Oxford Insurance Company Generic Certificate of Coverage, 2018.

## Policy History/Revision Information

Date	Summary of Changes
05/01/2023	<p><b>Applicable Codes</b></p> <ul style="list-style-type: none"><li>Updated list of experimental, investigational, or unproven and not medically necessary Category III codes and corresponding reference links to applicable Clinical Policies; added CPT codes:<ul style="list-style-type: none"><li>0184T for <a href="#">Transanal Endoscopic Microsurgery (TEMS)</a></li><li>0402T for <a href="#">Corneal Collagen Cross-Linking</a></li></ul></li></ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"><li>Archived previous policy version EXPERIMENTAL 004.1</li></ul>

## Instructions for Use

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Oxford Clinical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.