healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	CPT Category III Codes		
Policy Number:	PO-RE-116v2		
Effective Date:	10/01/2024	**Last Approval Date:**	12/02/2025

I. Policy Description

This policy applies to all healthcare providers submitting claims to Healthfirst for services that include CPT Category III codes. Because of the specific purpose CPT Category III codes serve, the item, service or procedure represented by these codes are generally considered experimental, investigational or unproven, unless there is an LCD or NCD Healthfirst Policy that specifically addresses coverage for a particular Category III code.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Medicare HMO and PPO
- Personal Wellness Plan (HARP)
- Essential Plan (EP)
- Managed Long Term Care Plan (MLTCP – Senior Health Partners)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Qualified Health Plan (QHP)

Policy Scope

CPT Category III codes are a set of temporary codes that allow data collection for emerging technologies, services, procedures, and service paradigms. These codes are intended to be used for data collection to substantiate widespread usage or to provide documentation for the Food and Drug Administration (FDA) approval process. The CPT Category III codes may not conform to one or more of the following CPT Category I code requirements:

- All devices and drugs necessary for performance of the procedure or service have received FDA clearance or approval when such is required for performance of the procedure or service.
- The procedure or service is performed by many physicians or other qualified health care professionals across the United States.
- 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.
- The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code change application.

Reimbursement Guidelines

- **Coverage Determination:** CPT Category III codes are non-covered or non-payable by Healthfirst. Claims with these codes will be denied.

- **Provider Notification:** Providers will be informed that the services or services associated with a CPT Category III code is non-covered or non-payable.

- **Claims Processing:** Claims containing CPT Category III codes will be denied with the following details:
  - Explanation of Payment (EOP): INFO QUALITY MEASURE
  - Remittance Advice Remark Code (RARC): N620, which states, “This procedure codes is for quality reporting.”
  - Denial Code: 246, which states, “This non-payable code is for required reporting only.”

Note: Although RARC N620 indicates quality reporting, it should be noted that CPT Category III codes are used for data collections and documentation for FDA approval, not quality reporting.

- Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, “Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process” in this section.*

Adjudication and Appeal Process

1. Reimbursement for Category III CPT Code services will be determined based on the provider’s contract and any applicable LCD, NCD, or Healthfirst related applicable policy.

2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

4. This policy is a provider resource for understanding Healthfirst’s reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. Refer to: Healthfirst Provider Manual Subsection 17.6, “Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process” in this section.

Please be advised that all services provided are subject to the member's individual benefit coverage

II. Applicable Codes

Code	Description	Comment

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Category III Codes long descriptors | AMA (ama-assn.org)
LCD - Category III Codes (L35490)
Article - Billing and Coding: Category III Codes (A56902)

VI. Revision History

Revision Date	Summary of Changes
12/3/2025	Updated the resources section

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.