Priority Health	BILLING POLICY No. 147
Category III Current Procedural Terminology (CPT) Codes	
Date of origin: Aug 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

CPT Category III codes are a set of temporary (T) codes assigned to emerging technologies, services, and procedures. These codes are intended to be used for data collection to substantiate more widespread usage or to provide documentation for the Food and Drug Administration (FDA) approval process. Category III codes can be identified by the T alpha character that follows the four initial numerical digits (i.e., four digits followed by the letter T). These codes are also referred to as T Codes (American Medical Association [AMA], 2019).

The use of a Category III code allows physicians and other qualified health care professionals to identify emerging technologies, services and procedures for clinical efficacy, utilization and outcomes. Category III codes are generally archived after five years and may or may not eventually receive a Category I CPT code. If a specific cross-referenced Category I code has not been established at the time of archiving, the service or procedure will be reported with a Category I unlisted code (AMA, 2019).

It is noted by the AMA that a service or procedure represented by a T code does not constitute a finding of support, or lack thereof with regard to clinical efficacy, safety, applicability or clinical practice. Typically, there is a lack of published, peer-review evidence supporting the clinical efficacy, safety, and applicability of these services to clinical practice nor are these services considered an established standard of care.

MEDICAL POLICY

Category III Current Procedural Terminology (CPT®) Codes # 91636

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Coding Guidelines
For specifics, please refer to the medical policy above.

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

DISCLAIMER
Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made