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USING CATEGORY III CODES



Five tips to help improve accuracy, payment, and compliance.

BY MATTHEW BAUGH, MHA, COT, OCS, OCSR

Accurate coding for emerging retinal technologies requires more than familiarity with the standard American Medical Association (AMA) Current Procedural Terminology (CPT) Category I and Healthcare Common Procedure Coding System (HCPCS) codes; it also requires understanding CPT Category III codes. These temporary tracking codes, or “T” codes, are increasingly common in retina as innovation accelerates, yet they remain a frequent source of confusion, denials, and compliance risk.

CPT Category III codes consist of four numeric characters followed by the letter “T.” Although they are valid CPT codes, they do not have assigned relative value units (RVUs) or national Medicare payment rates. As a result, coverage and carrier pricing for reimbursement are determined by the Medicare Administrative Contractor (MAC) or the individual payer.

The following five practical tips outline how retina practices can use CPT Category III codes correctly to improve payer outcomes and position emerging services for future CPT Category I promotion.

TIP NO. 1: DON'T DEFAULT TO PATIENT PAY

A common misconception is that Category III codes are inherently noncovered and should automatically be billed to the patient. However, Category III status does not always mean investigational or noncovered. Rather, when a procedure is best described with a Category III code, it should be billed as such on the claim. Coverage decisions are based on medical necessity and payer policy—not the code category alone. Bypassing payer adjudication increases compliance risk and may leave reimbursement uncollected.

Verify payer coverage and submit the claim to the payer first. When Medicare Part B coverage is uncertain or considered noncovered, the physician is required to obtain

a valid Advance Beneficiary Notice (ABN), rather than defaulting to self-pay.¹

Practical Considerations

- Verify written payer policies for each Category III code used.
- Use ABNs with Medicare Part B patients when coverage is uncertain.
- Educate front desk and billing staff that Category III does not equate to automatic patient responsibility.

TIP NO. 2: REPORT CATEGORY III CODES INSTEAD OF UNLISTED CODES

When a Category III code exists that accurately describes the service performed, it must be reported instead of an unlisted Category I code. Substituting an unlisted code (eg, CPT code 67299, unlisted code, posterior segment) when a Category III option is available is incorrect coding and may trigger denials or post-payment review.

A retina-specific example is 0810T for subretinal injection of a pharmacologic agent (including vitrectomy and retinotomy), such as voretigene neparvovec-rzyl (Luxturna, Spark Therapeutics). Note: It would not be appropriate to bill CPT code 67036, pars plana vitrectomy and/or 67299 in place of or together with 0810T due to the descriptor.

Using the correct Category III code allows payers to price the service appropriately and supports the AMA CPT Editorial Panel in collecting usage data for a new and emerging service required for potential promotion to Category I status.²

Practical Considerations

- Use audit charge masters and electronic health record order sets to ensure Category III codes are available and mapped correctly.

A COMMON MISCONCEPTION IS THAT CATEGORY III CODES ARE INHERENTLY NONCOVERED AND SHOULD AUTOMATICALLY BE BILLED TO THE PATIENT. HOWEVER, CATEGORY III STATUS DOES NOT ALWAYS MEAN INVESTIGATIONAL OR NONCOVERED.

- Build payer-specific rules to prevent staff from defaulting to unlisted codes.

TIP NO. 3: EXPECT HEIGHTENED DOCUMENTATION SCRUTINY

Because Category III codes lack RVUs and national payment rates, documentation often determines whether a claim is paid and is considered medically necessary per the payers. Some MACs require submission of operative notes or supporting records upon claim acceptance for all Category III services.³ Failure to submit properly or respond in a timely manner will prompt an additional documentation request, which can delay or deny payment.

Documentation should clearly reflect the full service performed, matching the Category III code descriptor, the clinical rationale and diagnosis, the operative or procedure notes (as appropriate), and the formal interpretation and report, when required.

Practical Considerations

- Create templated operative notes with language and supporting documentation for each Category III code used.
- Train staff on MAC paperwork workflows for submission.
- Document measurable findings and their effect on clinical decision making.

TIP NO. 4: ALIGN PROFESSIONAL AND FACILITY BILLING

Many Category III services involve both professional and facility components. Misalignment between physician and facility billing can result in duplicate charges, missing modifiers, or denials. For example, when 0810T is performed in a facility, the physician reports 0810T, and the facility should also report 0810T and the drug. Clarifying the appropriate code(s) and who bills each component before claim submission is essential.

Practical Considerations

- Develop a shared billing checklist with the ambulatory surgery center or hospital partners.
- Confirm modifier usage (-RT/-LT, -50) and drug billing responsibilities.

TIP NO. 5: TRACK SEMIANNUAL UPDATES AND CODE TRANSITIONS

Category III codes are temporary by design and are released twice yearly (January and July). They are assigned a defined sunset date, which represents the point at which the AMA reevaluates the code based on usage and clinical evidence. At that time, a code may be promoted to a Category I permanent code, revised, or deleted, if adoption had been limited. Their sunset date can also be extended if more data are needed.

Retina has seen this lifecycle repeatedly:

- 0465T (suprachoroidal injection) was replaced by Category I 67516 in 2024.
- Subretinal delivery was assigned to Category III (0810T) in 2023.
- New technologies, such as photobiomodulation therapy (0936T), are also currently tracked under Category III.

Failure to monitor updates can result in the use of deleted codes or missed billing opportunities.

Practical Considerations

- Schedule internal CPT reviews every January and July.
- Update superbills, electronic health record pick lists, and charge masters promptly.
- Educate clinicians and staff on coding changes before patient care is delivered.

RETINA-SPECIFIC CATEGORY III EXAMPLES

- **0472T:** Device evaluation, interrogation, and initial programming of intraocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional.
 - New code effective July 1, 2017
 - Sunset January 2028
- **0506T:** Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report.
 - New code effective July 2018
 - Sunset January 2029

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- **0810T:** Subretinal injection of a pharmacologic agent, including vitrectomy and one or more retinotomies.
 - New code January 1, 2023
 - Sunset January 2029
- **0936T:** Photobiomodulation therapy of retina, single session.
 - New code effective January 1, 2025
 - Sunset January 2030

New in 2026

One new Category III code relevant to retina practice took effect in 2026.

- **0996T:** Insertion and scleral fixation of a capsular bag prosthesis containing an intraocular lens, with vitrectomy, including removal of the crystalline lens or dislocated intraocular lens when performed.
 - New code effective January 1, 2026
 - Sunset January 2030

Do not bill separately for cataract extraction, IOL insertion or exchange, or vitrectomy codes when reporting this code.

If a vitrectomy and removal of the crystalline lens or removal of a dislocated intraocular lens are performed *without* insertion with scleral fixation of a capsular bag prosthesis, this code should not be reported; instead, the appropriate vitrectomy and lens-related procedure codes should be used.

WHY ACCURATE REPORTING MATTERS

Suprachoroidal injections provide a clear example of why proper Category III reporting is essential. Early services were reported with 0465T, generating the usage data needed for promotion to permanent Category I code 67516 in 2024. CPT Category III codes represent the leading edge of retina innovation. Treating them as automatically noncovered services increases compliance risk and forfeits legitimate reimbursement. Submitting claims to payers, documenting thoroughly, coordinating professional and facility billing, and tracking semiannual CPT updates allows practices to be paid appropriately today—while supporting the pathway to permanent codes tomorrow. ■

1. How to use the advance beneficiary notice. American Academy of Ophthalmology. Updated February 2, 2026. Accessed February 10, 2026. www.aao.org/practice-management/news-detail/how-to-use-abn
2. CPT Editorial Panel. American Medical Association. Accessed February 10, 2026. tinyurl.com/mmw878e
3. First Coast and Novitas introduce new category III code documentation requirements. American Academy of Ophthalmology. February 14, 2024. Accessed February 10, 2026. tinyurl.com/y2nwazyk

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- Financial disclosure: None