AAOS American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Position Statement

Reimbursement for Approved Category I CPT Codes

This Position Statement was developed as an educational tool based on the opinion of the authors. It is not a product of a systematic review. Readers are encouraged to consider the information presented and reach their own conclusions.

AMA's Current, Procedural Terminology (CPT) codes are divided into three categories. Category I codes are for well-established services and procedures. Category II codes are used for performance measurement, data collection and test results, among other similar activities. Category III codes are temporary codes for emerging technology, services and procedures.

The AAOS believes unequivocally that if a service or procedure has a Category I CPT code, it is not experimental or investigational. Therefore, payers should not deny reimbursement for these services and procedures when they are medically necessary.[1] When payers do otherwise, they threaten the health of the public and unjustifiably interfere with the physician/patient relationship.

All Category I codes have been reviewed by the American Medical Association's Current Procedural Terminology (CPT) Editorial Panel and have met the following criteria:

- the service/procedure necessary for the procedure has received approval from the Food and Drug Administration (FDA) for the specific use of devices or drugs;
- the suggested procedure/service is a distinct service performed by many physicians or other qualified health professionals across the United States;
- the suggested service/procedure and clinical efficacy of the service/procedure is well established and documented in peer review literature that meets the requirements set in the code change proposal form;
- the suggested service/procedure is performed with the frequency consistent with the intended clinical use;
- the suggested service/procedure is neither a fragmentation of an existing procedure/service nor currently reportable by one or more existing codes; and
- the procedure or service is consistent with current medical practice.

Therefore, when a physician provides such a service or procedure and has documented his or her work properly and according to payer guidelines, the payer should not deny reimbursement for that service or procedure by claiming it is experimental or investigational.

[1] In Section 7.16 of the May 21, 2003 'Aetna class action law suit' Settlement Agreement, 'medical necessity' is defined as "health care services that a physician, exercising prudent clinical judgment, would provide to a patent for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis and treatment of the patient's illness, injury or disease."

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