CPT® Category III Codes

Most recent changes to the CPT® Category III Codes document

- Addition of 20 Category III codes (0791T-0810T), guidelines, and parenthetical notes accepted by the CPT Editorial Panel at the September 2022 meeting.

*Code numbers 0784T-0790T have been reserved and will be released with the full code set in CPT 2024.

CPT® Category III Codes

The following CPT codes are an excerpt of the CPT Category III code set, a temporary set of codes for emerging technologies, services, procedures, and service paradigms. For more information on the criteria for CPT Category I, II and III codes, see Applying for Codes.

To assist users in reporting the most recently approved Category III codes in a given CPT cycle, the AMA’s CPT website publishes updates of the CPT Editorial Panel (Panel) actions of the Category III codes in July and January according to the Category III Code Semi-Annual Early Release Schedule. This was approved by the CPT Editorial Panel as part of the 1998-2000 CPT-5 projects. Although publication of Category III codes through early release to the CPT website allows for expedient dispersal of the code and descriptor, early availability does not imply that these codes are immediately reportable before the indicated implementation date.

Publication of the Category III codes to this website takes place on a semiannual basis when the codes have been approved by the CPT Editorial Panel. The complete set of Category III codes for emerging technologies, services, procedures, and service paradigms are published annually in the code set for each CPT publication cycle.

As with CPT Category I codes, inclusion of a descriptor and its associated code number does not represent endorsement by the AMA of any particular diagnostic or therapeutic procedure or service. Inclusion or exclusion of a procedure or service does not imply any health insurance coverage or reimbursement policy.

Background Information for Category III Codes

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 (ie, 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.

Category III codes are not developed as a result of Panel review of an incomplete proposal, the need for more information, or
a lack of CPT Advisory Committee support of a code-change application.

CPT Category III codes are not referred to the AMA-Specialty RVS Update Committee (RUC) for valuation because no relative value units (RVUs) are assigned to these codes. Payments for these services or procedures are based on the policies of payers and not on a yearly fee schedule.

**Category III Codes for CPT 2024**

It is important to note that, because future CPT Editorial Panel or Executive Committee actions may affect these items, codes and descriptor language may differ at the time of publication. In addition, future Panel actions may result in the conversion of a Category III code to a Category I code and/or gaps in code number sequencing. A cross-reference will be placed in the Category III section of the CPT code set to direct users to the newly established CPT Category I code.

The following introductory language for this code section explains the purpose of these codes. Unless otherwise indicated, the symbol ● indicates new procedure codes that will be added to the CPT code set in 2024.

**Category III Codes**

The following section contains a set of temporary codes for emerging technologies, services, procedures, and service paradigms. Category III codes allow data collection for these services or procedures, unlike the use of unlisted codes, which does not offer the opportunity for the collection of specific data. If a Category III code is available, this code must be reported instead of a Category I unlisted code. This is an activity that is critically important in the evaluation of health care delivery and the formation of public and private policy. The use of Category III codes allows physicians and other qualified health care professionals, insurers, health services researchers, and health policy experts to identify emerging technologies, services, procedures, and service paradigms for clinical efficacy, utilization, and outcomes.

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. The codes in this section may not conform to the usual requirements for CPT Category I codes established by the CPT Editorial Panel. For Category I codes, the Panel requires that the service or procedure be performed by many health care professionals in clinical practice in multiple locations and that FDA approval, as appropriate, has been received. The nature of emerging technologies, services, procedures, and service paradigms is such that these requirements may not be met. For these reasons, temporary codes for emerging technologies, services, procedures, and service paradigms have been placed in a separate section of the CPT code set and the codes are differentiated from Category I CPT codes by the use of the alphanumeric character.

Services and procedures described in this section make use of alphanumeric characters. These codes have an alpha character as the 5th character in the string (ie, four digits followed by the letter T). The digits are not intended to reflect the placement of the code in the Category I section of CPT nomenclature. Codes in this section may or may not eventually receive a Category I CPT code. In either case, in general, a given Category III code will be archived five years from the 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 (eg, addition of parenthetical, instructions, reinstatement). Services and procedures described by Category III codes which have been archived after five years, without conversion, must be reported using the Category I unlisted code unless another specific cross-reference is established at the time of archiving. New codes or revised codes in this section are released semi-annually via the AMA CPT website to expedite dissemination for reporting. Codes approved for deletion are published annually with the full set of temporary codes for emerging technology, services, procedures, and service paradigms in the CPT code set. See the Introduction section of the CPT code set for a complete list of the dates of release and implementation.

It is important to note that further CPT Editorial Panel or Executive Committee actions may affect these codes and/or descriptors. For this reason, code numbers and/or descriptor language in the CPT code set may differ at the time of publication. In addition, further Panel actions may result in gaps in code number sequencing.
The following Category III codes, guidelines, and parenthetical notes were accepted and/or revised at the September 2022 CPT Editorial Panel meeting for the 2024 CPT production cycle. However, due to Category III code’s early-release policy, these codes are effective on July 1, 2023, following the six-month implementation period, which begins January 1, 2023.

<table>
<thead>
<tr>
<th>Code</th>
<th>Long Code Descriptor</th>
<th>Released toAMA Website</th>
<th>Effective Date</th>
<th>Publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>0632T</td>
<td>Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance.&lt;br&gt;(Do not report 0632T in conjunction with 36013, 36014, 36015, 75741, 75743, 75746, 93451, 93453, 93456, 93460, 93503, 93505, 93568, 93593, 93594, 93596, 93597)&lt;br&gt;▶(For percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance, use 0793T)▶</td>
<td>Parenthetical Note Released to AMA Website December 29, 2022</td>
<td>Parenthetical Note Effective July 1, 2023</td>
<td>CPT® 2024</td>
</tr>
<tr>
<td>0775T</td>
<td>▶Code 27279 describes percutaneous arthrodesis of the sacroiliac joint using a minimally invasive technique to place an internal fixation device(s) that passes through the ilium, across the sacroiliac joint, and into the sacrum, thus transfixing the sacroiliac joint. Report 0775T for the percutaneous placement of an intra-articular stabilization device into the sacroiliac joint using a minimally invasive technique that does not transfix the sacroiliac joint. For percutaneous arthrodesis of the sacroiliac joint utilizing both a transfixation device and intra-articular implant(s), use 27279 08097.▶&lt;br&gt;Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s])</td>
<td>Revised Guidelines Released to AMA Website December 29, 2022</td>
<td>Revised Guidelines Effective July 1, 2023</td>
<td>CPT® 2024</td>
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<tr>
<td>0791T</td>
<td>Motor-cognitive, semi-immersive virtual reality–facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)&lt;br&gt;▶(Use 0791T in conjunction with 97116)▶</td>
<td>December 29, 2022</td>
<td>June 1, 2023</td>
<td>CPT® 2024</td>
</tr>
<tr>
<td>0792T</td>
<td>Application of silver diamine fluoride 38%, by a physician or other qualified health care professional</td>
<td>December 29, 2022</td>
<td>July 1, 2023</td>
<td>CPT® 2024</td>
</tr>
<tr>
<td>0793T</td>
<td>Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance&lt;br&gt;▶(Do not report 0793T in conjunction with 75746, 93568, 93576)&lt;br&gt;▶(For percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance, use 0632T)▶</td>
<td>December 29, 2022</td>
<td>July 1, 2023</td>
<td>CPT® 2024</td>
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<td></td>
<td>▶Pharmac-o-oncologic Algorithmic Treatment Ranking◀</td>
<td>December 29, 2022</td>
<td>July 1, 2023</td>
<td>CPT® 2024</td>
</tr>
</tbody>
</table>

▶Pharmac-o-oncologic Algorithmic Treatment Ranking◀<br>▶Code 0794T (pharmac-o-oncologic treatment ranking) represents rules based algorithm–generated match scores that rank available monotherapies and drug combinations according to their ability to target the patient’s specific cancer biomarkers. These pharmac-o-oncologic treatment ranking options are based only on current Food and Drug Administration (FDA)-approved drugs but may include both on-label and off-label uses for targeted therapies, and additional information may also be provided on potential active clinical trials that include specifically matched, currently available, therapy options. Code 0794T includes time spent by the physician, qualified health care professional, or clinical staff in submitting the patient's clinical and existing molecular, laboratory, or pathology result data for algorithmic assessment. Only existing result data should be submitted without alteration of original results and interpretations (eg, variant calls or expression markers) from those separately reported by the original performing clinical

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>CPT 2024</th>
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</thead>
<tbody>
<tr>
<td>0794T</td>
<td></td>
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<tr>
<td>0795T</td>
<td>Patient-specific, assistive, rules-based algorithm for ranking pharmaco-oncologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology, immunohistochemical, or other pathology results which have been previously interpreted and reported separately.</td>
<td></td>
</tr>
<tr>
<td>0796T</td>
<td>right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)</td>
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<tr>
<td>0797T</td>
<td>right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)</td>
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</tbody>
</table>

**Dual-Chamber Leadless Pacemaker**

A complete dual-chamber leadless pacemaker system includes two pulse generators, each with a built-in battery and electrode. Implantation of this system is performed using a catheter under fluoroscopic guidance via transvenous access. One pacemaker is implanted in the right atrium, and one is implanted in the right ventricle. Rarely, for clinical reasons, a complete dual-chamber leadless pacemaker system may be completed in stages, with one pacemaker implanted into the right ventricle at the initial procedure and the other implanted into the right atrium at a subsequent session. An existing single-chamber right ventricular leadless pacemaker may be upgraded to a complete dual-chamber leadless pacemaker system by implantation of a right atrial leadless pacemaker.

For insertion of a complete dual-chamber leadless pacemaker system, report 0795T. For insertion of a leadless pacemaker into the right atrium when a single-chamber right ventricular leadless pacemaker already exists, in order to complete the dual-chamber leadless pacemaker system, report 0796T. For insertion of only the right ventricular pacemaker component of a dual-chamber leadless pacemaker system, report 0797T. For removal of a complete dual-chamber leadless pacemaker system, report 0798T. For removal of only the right atrial leadless pacemaker component of a complete dual-chamber leadless pacemaker, report 0799T. For removal of only the right ventricular leadless pacemaker component of a complete dual-chamber leadless pacemaker, report 0800T. For removal and replacement of a complete dual-chamber leadless pacemaker system, report 0801T. For removal and replacement of only one pacemaker component of a complete dual-chamber leadless pacemaker system, report 0802T for the right atrial pacemaker component or 0803T for the right ventricular pacemaker component.

Right heart catheterization (93451, 93453, 93456, 93457, 93460, 93461, 93593, 93594, 93596, 93597) may not be reported in conjunction with dual-chamber leadless pacemaker codes 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T unless complete right heart catheterization is performed for an indication distinct from the dual-chamber leadless pacemaker procedure.

For programming device evaluation of a dual-chamber leadless pacemaker system, report 0804T. Device evaluation code 93279 may not be reported in conjunction with dual-chamber leadless pacemaker system codes 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T.

Radiological supervision and interpretation, fluoroscopy (76000, 77002), ultrasound guidance for vascular access (76937), right ventriculography (93566), and femoral venography (75820) are included in the leadless pacemaker procedures, when performed.

Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular pacemaker components)

(Do not report 0795T in conjunction with 75820, 76000, 76937, 77002, 93566)
Do not report 0795T, 0796T, 0797T in conjunction with 93451, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598, unless complete right heart catheterization is performed for indications distinct from the leadless pacemaker procedure.

Do not report 0796T, 0797T in conjunction with 33274, 75820, 76000, 76937, 77002, 93566, 0795T).

Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (ie, right atrial and right ventricular pacemaker components)

December 29, 2022

July 1, 2023

CPT® 2024

0798T

Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (ie, right atrial and right ventricular pacemaker components)

December 29, 2022

July 1, 2023

CPT® 2024

0799T

right atrial pacemaker component

December 29, 2022

July 1, 2023

CPT® 2024

0800T

right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)

December 29, 2022

July 1, 2023

CPT® 2024

0801T

Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; dual-chamber system (ie, right atrial and right ventricular pacemaker components)

December 29, 2022

July 1, 2023

CPT® 2024

0802T

right atrial pacemaker component

December 29, 2022

July 1, 2023

CPT® 2024

0803T

right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)

December 29, 2022

July 1, 2023

CPT® 2024

0804T

Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers

December 29, 2022

July 1, 2023

CPT® 2024

0805T, 0806T are used to report transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]).

Codes 0805T, 0806T include the work, when performed, of vascular access, placing the access sheath, transseptal puncture, advancing the caval valve delivery systems into position, repositioning the device(s) as needed, and deploying the device(s).

Angiography and radiological supervision and interpretation performed to guide CAVI (eg, guiding device placement and documenting completion of the intervention) are included in these codes.

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598) should not be used with 0805T, 0806T to report:
1. Contrast injections, angiography, road-mapping, and/or fluoroscopic guidance for the transcatheter CAVI,
2. Left ventricular angiography to assess tricuspid regurgitation for guidance of the transcatheter CAVI, or
3. Right and left heart catheterization for hemodynamic measurements before, during, and after transcatheter superior and inferior vena cava prosthetic valve implantation for guidance.

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598) and diagnostic coronary angiography codes (93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564) may be reported with 0805T, 0806T, representing separate and distinct services from CAVI, if:
1. No prior study is available and a full diagnostic study is performed, or
2. A prior study is available, but as documented in the medical record:
   a. There is inadequate visualization of the anatomy and/or pathology, or
   b. The patient’s condition with respect to the clinical indication has changed since the prior study, or
   c. There is a clinical change during the procedure that requires new evaluation.

For same session or same day diagnostic cardiac catheterization services, the appropriate diagnostic cardiac catheterization code(s) may be reported by appending modifier 59 indicating separate and distinct procedural service from the transcatheter superior and inferior vena cava prosthetic valve implantation procedures.

Percutaneous coronary interventional therapeutic procedures may be reported separately, when performed.

When transcatheter ventricular support is required in conjunction with CAVI, the appropriate ventricular assist device (VAD) procedure codes (33990, 33991, 33992, 33993, 33995, 33997) or balloon pump insertion codes (33967, 33970, 33973) may be reported.

When cardiopulmonary bypass is performed in conjunction with CAVI, 0805T and 0806T may be reported with the appropriate add-on code for percutaneous peripheral bypass (33367), open peripheral bypass (33368), or central bypass (33369).

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**0805T**

Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach

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**0806T**

open femoral vein approach

▶(Do not report 0805T, 0806T in conjunction with 33210, 33211 for temporary pacemaker insertion) │

▶(Do not report 0805T, 0806T in conjunction with 93451, 93453, 93456, 93457, 93460, 93461, 93503, 93566, 93593, 93594, 93596, 93597, for diagnostic right heart catheterization procedures intrinsic to the superior and inferior vena cava valve implantations) ◄

▶(Do not report 0805T, 0806T in conjunction with 93662 for imaging guidance with intracardiac echocardiography) ◄

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**0807T**

Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report

▶(Do not report 0807T in conjunction with 76000, 78579, 78582, 78598) ◄

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Updated December 29, 2022
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Date</th>
<th>Effective Date</th>
<th>CPT Edition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0808T</td>
<td>in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report</td>
<td>December 29, 2022</td>
<td>July 1, 2023</td>
<td>CPT® 2024</td>
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<td></td>
<td>(Do not report 0808T in conjunction with 71250, 71260, 71270, 71271, 76000, 78579, 78582, 78598)</td>
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<td>0809T</td>
<td>Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, placement of transfixing device(s) and intra-articular implant(s), including allograft or synthetic device(s)</td>
<td>December 29, 2022</td>
<td>July 1, 2023</td>
<td>CPT® 2024</td>
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<td></td>
<td>(For bilateral procedure, report 0809T with modifier 50)</td>
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<td>0810T</td>
<td>Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies</td>
<td>December 29, 2022</td>
<td>July 1, 2023</td>
<td>CPT® 2024</td>
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<td></td>
<td>(Report medication separately)</td>
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<tr>
<td></td>
<td>(Do not report 0810T in conjunction with 67036, 67039, 67040, 67041, 67042, 67043)</td>
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