CPT® Category III Codes

Most recent changes to the CPT® Category III Long Descriptor Document

- Revision of 4 codes (0805-0806T, 0882T-0883T), addition of 28 Category III codes (1026T-1053T), and the addition and revision of guidelines and parenthetical notes accepted by the CPT Editorial Panel at the September 2025 meeting.
- Update code descriptor for code 1042T.

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 2027
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 2027.

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 2025 CPT Editorial Panel meeting for the 2027 CPT production cycle. However, due to Category III code's early-release policy, these codes are effective on July 1, 2026, following the six-month implementation period, which begins January 1, 2026.

***Resequenced codes 1030T-1035T will follow code 0562T and code 1043T will follow code 0698T.**

Code	Long Code Descriptor	Released to AMA Website	Effective Date	Publication
0559T +0560T	Codes 0559T, 0560T represent production of 3D-printed models of individually prepared and processed components of structures of anatomy. These individual components of structures of anatomy include, but are not limited to, bones, arteries, veins, nerves, ureters, muscles, tendons and ligaments, joints, visceral organs, and brain. Each 3D-printed anatomic model of a structure can be made up of one or more separate components. The 3D anatomic printings can be 3D printed in unique colors and/or materials. Codes 0561T, 0562T represent the production of 3D-printed cutting or drilling guides using individualized imaging data. 3D-printed guides are cutting or drilling tools used during surgery and are 3D printed so that they precisely fit an individual patient's anatomy to guide the surgery. A cutting guide does not have multiple parts, but instead is a unique single tool. It may be necessary to make a 3D-printed model and a 3D-printed cutting or drilling guide on the same patient to assist with surgery. ►When 3D printing makes use of files created more than 30 days prior, originally reported using 1030T, 1031T, 1032T, 1033T, 1034T, 1035T, that have not been altered in the interim, report 3D-printing codes 0559T, 0560T, 0561T, 0562T with modifier 52.◄ Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure) (Use 0560T in conjunction with 0559T) ►(Do not report 0559T, 0560T in conjunction with 76376, 76377, 1030T, 1031T, 1032T, 1033T, 1034T, 1035T)◄	**Revised Guidelines and Parenthetical Note Released** December 30, 2025	**Revised Guidelines and Parenthetical Note Effective** July 1, 2026	**Revised Guidelines and Parenthetical Note Publication** CPT® 2027
0561T +0562T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide each additional anatomic guide (List separately in addition to code for primary procedure) (Use 0562T in conjunction with 0561T) ►(Do not report 0561T, 0562T in conjunction with 76376, 76377, 1030T, 1031T, 1032T, 1033T, 1034T, 1035T)◄	**Revised Parenthetical Note Released** December 30, 2025	**Revised Parenthetical Note Effective** July 1, 2026	**Revised Parenthetical Note Publication** CPT® 2027
	►Surface Mesh Representations and Applications: Digital 3D Modeling and Analysis◄ ►Codes 0559T, 0560T, 0561T, 0562T and 1030T, 1031T, 1032T, 1033T, 1034T, 1035T describe repurposing volumetric medical imaging out of the traditional digital imaging and communication in medicine (DICOM) format and into surface mesh files, which can be further transformed into clinically relevant digital three-dimensional (3D) models, some of which remain digital and others that are subsequently printed. These digital (non-printed) 3D models (technically referred to as "final anatomic representations" [FARs]) can be modified and manipulated to improve their clinical utility (eg, by creating digital simulations in which there is a virtual resection of anatomy or design of a digital graft/implant/guide). They can also be used for computational analyses such as computational fluid dynamics and finite element analyses. Surface mesh files are also the basis of physical, 3D-printed models and guides, which are reported with codes 0559T, 0560T, 0561T, 0562T. These 3D printing codes include the work of creating a surface mesh/digital 3D model; any digital	December 30, 2025	July 1, 2026	CPT® 2027

	manipulations; preparing the file(s) for 3D printing; the 3D printing itself; and post-processing of the physical printed parts for patient care. The work associated with creating strictly digital (non-printed) representations of patient-specific anatomy is described by 1030T, 1031T, 1032T, 1033T, 1034T, 1035T. Due to the highly iterative nature of the work of initially creating, subsequent refining, and applying digital 3D models, this family of codes is reported based on the cumulative amount of time spent by the reporting provider during a 30-day period, which starts with the first day of working on the patient's digital 3D model. If the patient's clinical scenario changes during the 30-day period (eg, the patient undergoes a procedure that changes the anatomy/physiology), then the period resets and the base code may be reported again. This iterative process is performed for a specific anticipated procedure, typically with the goal of detailing the approach for that procedure. The process typically involves a team, led by an interpreting/supervising physician or other qualified health care professional (QHP) but including trained clinical staff, such as technologists and engineers. The cumulative time reported should only reflect the time of the interpreting/supervising physician or other QHP related to the creation/refinement of the digital (nonprinted) 3D model, the creation/refinement of the digital simulation (when performed), and computational analyses (when performed). The time reported should **not** include any clinical staff time nor any interventionalist time spent interacting with the digital 3D model/simulation for the purposes of preprocedural planning. Codes 1030T, 1032T, 1034T should only be reported once per anticipated procedure. Codes 1030T, 1031T, 1032T, 1033T, 1034T, 1035T should not be reported with or in place of codes that include components of digital 3D modeling/reconstruction (ie, 31627, 75580, 76376, 76377, 0944T). Codes 1030T, 1031T are reported for the creation of a patient-specific digital 3D model without subsequent digital simulation and without subsequent computational analyses. Codes 1032T, 1033T are reported for the creation of a patient-specific digital 3D model and its use for a digital simulation. Digital simulations can include multiple iterations of designing digital intraprocedural templates/guides, virtual "trialing" of various implants/designs/surgical approaches, or virtual contingency planning for potential complications. Codes 1034T, 1035T are reported for the creation of a patient-specific digital 3D model, its use for a digital simulation, and performing computational analyses using that model/simulation. Examples of these computational analyses include computational fluid dynamics (eg, to estimate the flow patterns after planned vascular alterations) and finite element analysis (eg, estimation of vessel wall strain). When 3D-printing makes use of files created more than 30 days prior, which were originally reported using 1030T, 1031T, 1032T, 1033T, 1034T, 1035T, that have not been altered in the interim, report 3D-printing codes 0559T, 0560T, 0561T, 0562T with modifier 52◄			
#●1030T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (eg, final anatomic representation [FAR]), cumulative time for up to 30 days; initial 30 minutes ►(Report 1030T only once per clinical scenario, per 30-day period. Additional time for the same clinical scenario within 30 days is reported with 1031T)◄			
#✚●1031T	each additional 30 minutes (List separately in addition to code for primary procedure) ►(Use 1031T in conjunction with 1030T)◄ ►(Do not report 1030T, 1031T in conjunction with 31627, 75580, 76376, 76377, 0559T, 0560T, 0561T, 0562T, 0944T, 1032T, 1033T, 1034T, 1035T)◄	December 30, 2025	July 1, 2026	CPT® 2027
#●1032T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (eg, final anatomic representation [FAR]) and digital simulation, cumulative time for up to 30 days; initial 60 minutes ►(Report 1032T only once per clinical scenario, per 30-day period. Additional time for the same clinical scenario within 30 days is reported with 1033T)◄	December 30, 2025	July 1, 2026	CPT® 2027

#✚●1033T	each additional 30 minutes (List separately in addition to code for primary procedure) ►(Use 1033T in conjunction with 1032T)◄ ►(Do not report 1032T, 1033T in conjunction with 31627, 76376, 76377, 0944T, 1030T, 1031T, 1034T, 1035T)◄	December 30, 2025	July 1, 2026	CPT® 2027
#●1034T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (eg, final anatomic representation [FAR]), digital simulation, and computational analyses (eg, computational fluid dynamics, finite element analysis), cumulative time for up to 30 days; initial 90 minutes ►(Report 1034T only once per clinical scenario, per 30-day period. Additional time for the same clinical scenario within 30 days is reported with 1035T)◄	December 30, 2025	July 1, 2026	CPT® 2027
#✚●1035T	each additional 30 minutes (List separately in addition to code for primary procedure) ►(Use 1035T in conjunction with 1034T)◄ ►(Do not report 1034T, 1035T in conjunction with 31627, 75580, 76376, 76377, 0944T, 1030T, 1031T, 1032T, 1033T)◄	December 30, 2025	July 1, 2026	CPT® 2027
#●1043T	►Code 1043T describes a point-of-care magnetic resonance (MR) test for liver assessment. This test does not include imaging, and is a test measuring one or more liver parameters, not requiring further professional interpretation. When proton density fat fraction (PDFF) is determined from a magnetic resonance imaging (MRI) study, report the appropriate MRI code rather than 1043T.◄ Quantitative magnetic resonance, without imaging, for analysis of liver tissue, including assessment of 1 or more parameters (eg, proton density fat fraction [PDFF], water diffusion, T1-water relaxation time), with automatically generated report ►(Do not report 1043T in conjunction with 74181, 74182, 74183, 0648T, 0649T, 0697T, 0698T)◄ ►(For magnetic resonance imaging studies of the liver, see 74181, 74182, 74183)◄ ►(For quantitative magnetic resonance for analysis of tissue composition utilizing data from an MRI of the same anatomy, see 0648T, 0649T, 0697T, 0698T)◄	December 30, 2025	July 1, 2026	CPT® 2027
	►Codes 0805T, 0806T are used to report transcatheter superior and/or 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~~Right 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:	December 30, 2025	July 1, 2026	CPT® 2027

▲0805T	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 (separate session) diagnostic right cardiac catheterization services where clinical necessity has been documented, 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/or 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). Transcatheter superior and/or inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach			
▲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)	December 30, 2025	July 1, 2026	CPT® 2027
✚▲0882T	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, ~~upper extremity,~~ minimum of 10 minutes; initial nerve (List separately in addition to code for primary procedure) ►(Use 0882T in conjunction with 64702, 64704, 64708, 64712, 64713, 64714, 64716, 64718, 64719, 64721, 64831, 64834, 64835, 64836, 64840, 64856, 64857, 64858, 64861, 64862, 64864, 64865, 64885, 64886, 64890, 64891, 64892, 64893, 64895, 64896, 64897, 64898, 64905, 64910, 64911, 64912)◄	December 30, 2025	July 1, 2026	CPT® 2027
✚▲0883T	each additional nerve (List separately in addition to code for primary procedure) (Use 0883T in conjunction with 0882T)	December 30, 2025	July 1, 2026	CPT® 2027
0944T	3D contour simulation of target liver lesion(s) and margin(s) for image-guided percutaneous microwave ablation (Report 0944T once per liver microwave ablation procedure) ►(Do not report 0944T in conjunction with 76376, 76377, 1030T, 1031T, 1032T, 1033T, 1034T, 1035T)◄	**Revised Parenthetical Note Released** December 30, 2025	**Revised Parenthetical Note Effective** July 1, 2026	**Revised Parenthetical Note Publication** CPT® 2027
●1026T	Transvaginal laser photobiomodulation therapy of pelvis, provided by a physician or other qualified health care professional	December 30, 2025	July 1, 2026	CPT® 2027

●1027T	►**Transvenous Phrenic Neurostimulation Therapy for Diaphragm Activation in Ventilated Patients**◄ ►Codes 1027T, 1028T, 1029T describe procedures that place a neurostimulation catheter in the superior vena cava and provide transvenous neurostimulation of the phrenic nerve(s) to increase diaphragmatic strength and improve weaning success in mechanically ventilated patients. These codes describe insertion, positioning, and therapy that includes mapping (capture of left and right phrenic nerve) and programming of a neurostimulation catheter with an external neurostimulation console that generates output to the electrodes on the neurostimulation catheter. Pressure data from an airway sensor is captured and used for synchronizing stimulation to inspiration during positioning, mapping, and therapy. Settings relative to the stimulation threshold (the minimal stimulation level to elicit diaphragm activation) are adjusted. Transvenous phrenic neurostimulation therapy is delivered in two daily sessions with 60 stimulations per session for a total of 120 stimulations per day. The transvenous neurostimulation catheter and external neurostimulation console are designed to operate in conjunction with mechanical ventilation in any ventilator mode. Report 1027T for the insertion of the catheter, repositioning, mapping and programming, and delivery of transvenous phrenic neurostimulation therapy. Separate therapy sessions are reported with 1028T, 1029T. Report 1028T when repositioning of the catheter (without removal) is necessary due to incomplete mapping or ineffective diaphragm contraction during a stimulation therapy session. For permanent phrenic nerve stimulation system placement and management, see 33276, 33277, 33278, 33279, 33280, 33281, 33287, 33288, 93150, 93151, 93152, 93153. For ventilation management, use 94002, 94003 when performed on the same day as transvenous phrenic stimulation for diaphragm activation in ventilated patients.◄ Percutaneous insertion or replacement of neurostimulation catheter via left subclavian or left jugular vein into the superior vena cava, with verification of capture of phrenic nerves, mapping and programming, and delivery of transvenous phrenic neurostimulation therapy in ventilated patients, with repositioning when performed, including imaging guidance ►(Do not report 1027T in conjunction with 33276, 33277, 33281, 33287, 33288, 76942)◄ ►(Do not report 1027T in conjunction with 1028T, when performed in the same session)◄	December 30, 2025	July 1, 2026	CPT® 2027
●1028T	Mapping and programming of neurostimulation catheter with delivery of transvenous phrenic neurostimulation therapy in ventilated patients, with repositioning and verification of left phrenic nerve capture, per session ►(Report 1028T in conjunction with 1027T, 1029T, when performed on the same day)◄ ►(Do not report 1028T in conjunction with 33281, 93150, 93151, 93152, 93153)◄ ►(Do not report 1028T in conjunction with 1027T, 1029T, when performed at the same session)◄	December 30, 2025	July 1, 2026	CPT® 2027
●1029T	Mapping and programming of neurostimulation catheter with delivery of transvenous phrenic neurostimulation therapy in ventilated patients, without catheter repositioning, per session ►(Report 1029T in conjunction with 1027T, 1028T, when performed on the same day)◄ ►(Do not report 1029T in conjunction with 93150, 93151, 93152, 93153)◄ ►(Do not report 1029T in conjunction with 1027T, 1028T, when performed at the same session)◄	December 30, 2025	July 1, 2026	CPT® 2027
●1036T	Noninvasive hemodynamic assessment with pulmonary pressures and ejection fraction when performed, including passive acquisition of acoustic and electrical signals, augmentative algorithmic analysis, and generation of a clinical report with review, interpretation, and clinical integration by a physician or other qualified health care professional	December 30, 2025	July 1, 2026	CPT® 2027

●1037T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant pancreatic tissue, including imaging guidance ►(For diagnostic CT, MRI, or ultrasound performed on the same day, 1037T may be separately reported)◄	December 30, 2025	July 1, 2026	CPT® 2027
●1038T	Autologous muscle cell therapy, injection(s) of muscle progenitor cells into the tongue, including esophagoscopy, when performed ►(Do not report 1038T in conjunction with 43197)◄	December 30, 2025	July 1, 2026	CPT® 2027
●1039T	Connectomic analysis of previously performed multi-modal brain magnetic resonance imaging (MRI) requiring physician or other qualified health care professional (QHP) analysis of software- and physician-generated structural and functional maps for integration of cortical grey matter correlation based on resting-state functional MRI and mapping of white matter connectivity based on diffusion-weighted MRI relative to brain regions, with physician or other QHP interpretation and report ►(Do not report 1039T in conjunction with 70551, 70552, 70553, 76376, 76377)◄ ►(For quantitative MRI analysis of the brain with comparison to prior MRI study, see 0865T, 0866T)◄	December 30, 2025	July 1, 2026	CPT® 2027
●1040T	Bronchoscopy, flexible, with bronchial cryotherapy, 1 lung, including trachea, when performed	December 30, 2025	July 1, 2026	CPT® 2027
●1041T	Augmentative algorithmic analysis of encephalographic waveforms to identify the source and propagation of epileptiform activity, including artifact reduction with analysis of 3D localization of spike sources throughout the examination, 3D animations over time of high-amplitude event locations, high-frequency activity locations, and temporal relationships among locations, with interpretation and report by physician or other qualified health care professional, related to a previously performed electroencephalogram (EEG) ►(Report 1041T once per uploaded EEG recording)◄	December 30, 2025	July 1, 2026	CPT® 2027
+●1042T	Implantation of absorbable urologic scaffold for ~~prosthetic~~ prostatic urethra restoration of reconstructed bladder neck and urethral anastomosis (List separately in addition to code for primary procedure) ►(Use 1042T in conjunction with 55840, 55842, 55845, 55866)◄ ►(Report 1042T once per procedure)◄	December 30, 2025 March 10, 2026	July 1, 2026	CPT® 2027
●1044T	Harvest of full-thickness skin for autologous heterogeneous skin-construct graft, including direct closure of donor site; first 5 sq cm or less	December 30, 2025	July 1, 2026	CPT® 2027
+●1045T	each additional 5 sq cm, or part thereof (List separately in addition to code for primary procedure) ►(Use 1045T in conjunction with 1044T)◄	December 30, 2025	July 1, 2026	CPT® 2027
●1046T	Autologous heterogeneous skin-construct graft application, trunk, arms, legs; first 50 sq cm or less, or 0.5% of body area of infants and children	December 30, 2025	July 1, 2026	CPT® 2027
+●1047T	each additional 50 sq cm, or each additional 0.5% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) ►(Use 1047T in conjunction with 1046T)◄	December 30, 2025	July 1, 2026	CPT® 2027
●1048T	Autologous heterogeneous skin-construct graft application, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 50 sq cm or less, or 0.5% of body area of infants and children	December 30, 2025	July 1, 2026	CPT® 2027

+●1049T	each additional 50 sq cm, or each additional 0.5% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) ►(Use 1049T in conjunction with 1048T)◄	December 30, 2025	July 1, 2026	CPT® 2027
●1050T	►**Subcutaneous Heart Failure Decompensation Monitoring**◄ ►A subcutaneous heart failure decompensation monitor is used to assist the physician or other qualified health care professional (QHP) in the management of heart failure. The device continuously collects physiologic data using multiple sensors that measure, at a minimum, heart rate, impedance, respiration rate, physical activity, and heart sounds. The monitor transmits data each time it is interrogated and each time an alert is issued to a secure website platform, which generates a report that is reviewed and interpreted by the physician or other QHP. The output includes daily measurements of physiologic data collected by the sensors, including historical trends up to the last interrogation, as well as an algorithmically derived heart failure decompensation index calculated by analysis of aggregate data trends from the physiologic sensors. If this composite index crosses a predefined threshold that suggests a patient's heart failure is worsening (decompensating), the system automatically sends alerts to the clinician (in addition to the scheduled interrogations). The physician or other QHP may interrogate the monitor, in-person or remotely, as often as needed. However, the proposed code for interrogation (1052T) may only be reported once per 30 days, regardless of how often the monitor is interrogated or the number of alerts generated. Do not report 1052T if the monitoring period is less than 10 days. A subcutaneous heart failure monitor programming evaluation may be performed in person or remotely. Programming device evaluation includes all components of the interrogation device evaluation. Therefore, 1052T (interrogation) may not be reported in conjunction with 1053T (programming). Devices with similar physiologic sensors for monitoring heart failure are used in certain implantable cardioverter-defibrillators (ICDs) and cardiac resynchronization therapy defibrillators (CRT-Ds) devices. These devices include transvenous leads in addition to sensors, which are different from the subcutaneous heart failure monitor that does not include any leads. The interrogation of the data from devices containing leads, with review, analysis, and interpretation, is reported using 93290 (in person) and 93297 (remote).◄ Insertion, subcutaneous heart failure decompensation monitor, containing sensors that measure, at a minimum, heart rate, impedance, respiration rate, physical activity, heart sounds ►(Do not report 1050T in conjunction with 1052T, 1053T)◄ ►(For insertion of a subcutaneous cardiac rhythm monitor, use 33285)◄	December 30, 2025	July 1, 2026	CPT® 2027
●1051T	Removal of subcutaneous heart failure decompensation monitor ►(Initial insertion or subsequent removal includes programming, analysis, and/or reprogramming of physiologic data elements, when performed)◄ ►(Do not report 1051T in conjunction with 1052T, 1053T)◄ ►(For removal of a subcutaneous cardiac rhythm monitor, use 33286)◄	December 30, 2025	July 1, 2026	CPT® 2027
●1052T	Interrogation device evaluation(s), (in person or remote) up to 30 days, insertable subcutaneous heart failure decompensation monitor, analysis of physiologic parameters, including, at a minimum, heart rate, impedance, respiration rate, physical activity, heart sounds, with generation of a report, review and interpretation by a physician or other qualified health care professional ►(Report 1052T only once per 30 days)◄ ►(Do not report 1052T in conjunction with 93290, 93297, 1050T, 1051T, 1053T)◄ ►(For interrogation and evaluation of implantable cardiovascular physiologic monitor system with transvenous leads, see 93290 [in person], 93297 [remote])◄	December 30, 2025	July 1, 2026	CPT® 2027
●1053T	Programming device evaluation (in person or remote) of subcutaneous heart failure decompensation monitor, with analysis of physiologic parameters, including, at a minimum, heart rate, impedance, respiration rate, physical activity, heart sounds, with generation of a report and review and interpretation by a physician or other qualified health care professional ►(Report 1053T only once per 30 days)◄	December 30, 2025	July 1, 2026	CPT® 2027

	►(Do not report 1053T in conjunction with 1050T, 1051T, 1052T)◄			