

Disclaimer

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Hybrid In-person/Virtual CPT Editorial Panel Meeting

**September 17-19, 2026
Thursday-Saturday**

CPT Editorial Panel Meeting

I. CALL TO ORDER

The CPT Editorial Panel in-person meeting was called to order by Christopher L. Jagmin, MD, CPT Editorial Panel Chair, on Thursday, September 17, 2026, at 8:08 am (Central Time). The Chair welcomed all public attendees and specialty societies and asked all to respect the confidentiality provisions. Attendees were reminded that all decisions made during the meeting are not final until the CPT data is posted to the AMA website, and additionally, that all material may be subject to required revisions.

All attendees are expected to exhibit respectful, professional and collegial behavior consistent with the AMA's Code of Conduct. Attendees were also reminded that the CPT process enjoys a high reputation due to the expertise, diligence and professionalism of all participants.

All Panel members, advisors, and other reviewers were informed that the discussion of issues should focus on the CPT code criteria.

Efficient Conduct:

- The purpose of the meeting is to allow Panel members to be informed about the matters at hand prior to making a decision.
- The focus of Panel discussion is on the code criteria.
- We ask that speakers refrain from reiteration of points that have already been raised during discussion.

**Category III Release Date Note: The release date may be delayed by up to 10 days based on the date of the CPT Panel fall meeting.*

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- The purpose of the meeting is not to count heads or debate.
- For those participants who may be asked to adhere to any requests for brevity, to stay on topic, or to limit your comments to the code criteria, these directions are intended to efficiently manage the business of the meeting and are not intended to offend or reprimand.

The Chair announced the following updates to the agenda:

Meeting Outcomes

Items at the **September 2026** Panel meeting **requiring** RUC valuation **surveys** will be **effective** January 1, 2028

Category III submissions approved by the Panel will be released October 1*, 2026, and become effective Jan. 1, 2027. Please note that release date may be delayed up to 10 days due to timing of the meeting.

Withdrawn by requestor/terminated (items appearing with asterisk were withdrawn on-site):

Tab	Agenda Item
4	Critical Care Services
6	Surgical Package Definition Revision-Pre-op Clearance
11	Percutaneous US Fragmentation and Aspiration-Elbow
12	Subtalar Sinus Tarsi Stabilization
16	Endoscopic Ablation-Posterior Nasal Nerve-Rev 31242
22	Tibial Intravascular Lithotripsy (IVL)
26	Machine Perfusion Services-Liver Allograft
30	Cranial Neurostimulator Subsection Revisions
32	Cryoneurolysis-Peripheral Nerve
38	Bone Marrow Biopsy-Revise 88305 88307
43	Intraoperative Monitoring
47	Extended Psychotherapy Services-Rev 90834 90837 (Terminated)
51	Provocation Testing-Revise 93024

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Tab	Agenda Item
52	Optical Coherence Tomography, Middle Ear*
53	Repetitive Transcranial Magnetic Stimulation
54	AI Algorithmic Acoustic and ECG Analysis*
58	Cat III- AI Spine and Orthopedic Surgical Stimulation
59	Cat III-AI ECG Risk-based Assessment*
61	Cat III-Histotripsy-Prostate Tissue*
64	Cat III-Non-invasive Intracranial Pressure Sensor Interrogation
66	Cat III-Occlusion w Catheter Seclusion-Incompetent Vein
74	Cat III-AI-CTA Derived by Algorithmic Analysis
80	Cat III-Lithotripsy w Intrarenal Pressure (IRP) Treatment
83	Cat III-Fluorescence Wound Imaging
89	Cat III-Visible-light Spectroscopy-Oxygenation Measurement
91	Cat III-AI-US Algorithmic Assessment-Middle Ear Effusion

The Chair announced that again the Panel was utilizing a consent agenda. He reminded the attendees that tabs were placed on the consent agenda ONLY if the panel reviewers and the applicants of the tab agreed that the proposed option be placed on the consent agenda. He also reminded all attendees that they had the ability to remove items from the consent agenda, without a second (items that were accepted on the consent agenda are noted in the new business section of these minutes).

The schedule for upcoming meetings was provided as follows:

CPT Editorial Panel Meetings for 2027

February 4-6, 2027	Los Angeles, CA	CPT Cycle 2029
May 6-8, 2027	Chicago, IL	CPT Cycle 2029

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September 16-18, 2027	Albuquerque, NM	CPT Cycle 2029
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II. MINUTES

May 2026 Panel Meeting Minutes

CPT Editorial Panel Vice-Chair Barbara S. Levy, MD, noted that all issues requiring resolution for the finalization of the May 2026 Meeting Minutes were completed prior to the Panel meeting and that no additional items required Panel review.

III. NEW BUSINESS

Tab 4-Critical Care Services-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 5-Alcohol-Substance Abuse Assessment

This action will be effective in the CPT 2028 code set.

The Panel accepted with modification Option D of this request to: (1) establish code 9940X as a parent, revise code 99408 as a child code, and revise the descriptor language for 99408, 99409 for reporting alcohol and/or non-tobacco substance “use” structured assessment and brief interventions of 5 to 14 minutes (9940X), 15 to 30 minutes (99408), and greater than 30 minutes (99409); (2) establish parenthetical note instruction that restricts reporting any assessment of less than 5 minutes of services (following code 9940X); (3) delete the parenthetical note following 99408 that instructs that 99408 may not be used for services of less than 15 minutes; (4) delete the parenthetical note following 99409 that restricts reporting 99409 in conjunction with 9940X, 99408; (5) delete parenthetical note instruction following 99409 that directs use of codes 9940X, 99408, and 99409 only for initial assessment and brief intervention; (6) revise the parenthetical note following 99409 by adding code 9940X to the listing; (7) revise a guideline within the Psychiatric Collaborative Care Management Services subsection by replacing “abuse” with “use”; and (8) revise the existing typical patient content for codes 99408, 99409.

The Panel modified this request by revising the parenthetical note following 9940X via relocation of code 9940X within the parenthetical note to be congruent with code convention.

Category I

Evaluation and Management

Preventive Medicine Services

Counseling Risk Factor Reduction and Behavior Change Intervention

New or Established Patient

Behavior Change Interventions, Individual

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#★▲●9940X Alcohol and/or substance (other than tobacco) use structured assessment and brief intervention services; 5 to 14 minutes

(Do not report 9940X for services of less than 5 minutes)

★▲▲ [99408] ~~Alcohol and/or substance (other than tobacco) abuse structured assessment screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes~~

(Do not report services of less than 15 minutes with [99408])

★▲▲ [99409] ~~Alcohol and/or substance (other than tobacco) abuse structured assessment screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes~~

(Services of less than 5 minutes may not be separately reported)

(Do not report [99409] in conjunction with 9940X, [99408])

(Do not report 9940X, [99408], [99409] in conjunction with [96160], [96161])

(Use [99408], [99409] only for initial screening assessment and brief intervention)

Psychiatric Collaborative Care Management Services

Psychiatric collaborative care services . . .

. . .

The behavioral health care manager providing other services in the same calendar month, such as psychiatric evaluation (90791, 90792), psychotherapy (90832, 90833, 90834, 90836, 90837, 90838), psychotherapy for crisis (90839, 90840), family psychotherapy (90846, 90847), multiple family group psychotherapy (90849), group psychotherapy (90853), smoking and tobacco use cessation counseling (99406, 99407), and alcohol and/or substance ~~abuse~~ use structured ~~screening assessment~~ and brief intervention services (9940X, 99408, 99409), may report these services separately. Activities for services reported separately are not included in the time applied to 99492, 99493, 99494.

Typical Patient (99408)

A 45-year-old male presenting for a wellness exam and screening revealed likely alcohol misuse.

REVISED Typical Patient (99409)

~~A 21-year-old college student reports to the school infirmary after injuring his leg after falling down several steps.~~

A 45-year-old male presenting for a wellness exam and screening revealed likely alcohol misuse.

Typical Patient (9940X)

A 45-year-old male presenting for a wellness exam and screening revealed likely alcohol misuse.

Tab 6-Surgical Package Definition Revision-Pre-op Clearance-Withdrawn

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This issue was withdrawn by the requestor prior to the meeting.

Tab 7-Destruction Premalignant Lesions

This action will be effective in the CPT 2028 code set.

The Panel accepted with modifications on-site Option C of this request to: (1) delete codes 17000, 17003, 17004; (2) establish new codes for cryosurgical destruction (17X05, 17X01, 17X02) and other than monotherapy cryosurgical destruction (17X06, 17X07, 17X03) of premalignant lesion(s); (3) revise guidelines under subsection Skin, Subcutaneous, and Accessory Structures/Excision—Benign Lesions; (4) remove all instances of deleted codes 17000, 17003, 17004 throughout the code set; (5) revise guidelines to replace “electrosurgical” with “destruction”; (6) revise guidelines to clarify that all destruction methods are included; (7) add new guidelines under Destruction, Benign or Premalignant Lesions to report different destruction methods used on a single lesion and how to report different surgical methods used by different lesions; (8) add and revise parenthetical notes to reflect the addition and deletion of codes; (9) add parenthetical notes throughout the family of codes regarding appropriate reporting; and (10) revise illustration under Destruction, Benign or Premalignant Lesions to delete 17004 and add new code 17X07.

The Panel modified the request by: (1) deleting the parenthetical note within the descriptors for 17X05, 17X01, 17X02, and retaining the term “cryosurgery”; (2) deleting a redundant listing 17X02 which is already addressed by the exclusionary parenthetical note following code 17X02; and (3) revising the typical patient for code 17X01 by deleting the phrase “to the additional second through 14”, adding “for each individual”, and changing “lesions” to “lesion”.

Category I

Surgery

Integumentary System

Skin, Subcutaneous, and Accessory Structures

Excision—Benign Lesions

Excision (including simple closure) of benign lesions of skin (eg, neoplasm, cicatricial, fibrous, inflammatory, congenital, cystic lesions), includes local anesthesia. See appropriate size and area below. For shave removal, see 11300 et seq, and for destruction ~~electrosurgical~~ and other methods see ~~17000~~ 17X05 et seq.

Excision is defined as full-thickness...

The closure of defects...

(For destruction [eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement] of benign lesions other than skin tags or cutaneous vascular proliferative lesions, see 17110, 17111; premalignant lesions, see ~~17000, 17003, 17004~~ 17X05, 17X01, 17X02, 17X06, 17X07, 17X03; cutaneous vascular proliferative lesions, see 17106, 17107, 17108; malignant lesions, see 17260-17286)

(For excision of cicatricial lesion[s] [eg, full thickness excision, through the dermis], see 11400-11446)

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(For incisional removal of burn scar, see 16035, 16036)

(For fractional ablative laser fenestration for functional improvement of traumatic or burn scars, see 0479T, 0480T)

(For fractional ablative laser treatment for hypertrophic burn, traumatic, and/or postoperative scar[s], see 17XX0, 17XX1, 17XX2, 17XX3, 17XX4, 17XX5, 17XX6, 17XX7)

Destruction

Destruction means the ablation of benign, premalignant or malignant tissues by any method, with or without curettement, including local anesthesia, and not usually requiring closure.

Any method includes cryosurgery, laser surgery, electrosurgery, chemosurgery, surgical curettement, or a combination of any modalities. Lesions include condylomata, papillomata, molluscum contagiosum, ~~herpetic lesions~~, warts (ie, common, plantar, flat), milia, or other benign, premalignant (eg, actinic keratoses), or malignant lesions.

(For destruction of lesion(s) in specific anatomic sites, see 40820, 46900-46917, 46924, 54050-54057, 54065, 56501, 56515, 57061, 57065, 67850, 68135)

(For laser treatment for inflammatory or autoimmune skin diseases, see 96920-96922)

(For paring or cutting of benign hyperkeratotic lesions (eg, corns or calluses), see 11055-11057)

(For sharp removal or electrosurgical destruction of skin tags and fibrocutaneous tags, see 11200, 11201)

(For cryotherapy of acne, use 17340)

(For initiation or follow-up care of topical chemotherapy (eg, 5-FU or similar agents), see appropriate office visits)

(For shaving of epidermal or dermal lesions, see 11300-11313)

(For excision of cicatricial lesion[s] [eg, full thickness excision, through the dermis], see 11400-11446)

(For incisional removal of burn scar, see 16035, 16036)

(For fractional ablative laser fenestration for functional improvement of traumatic or burn scars, see 0479T, 0480T)

(For fractional ablative laser treatment for hypertrophic burn, traumatic, and/or postoperative scar[s], see 17XX0, 17XX1, 17XX2, 17XX3, 17XX4, 17XX5, 17XX6, 17XX7)

Destruction, Benign or Premalignant Lesions

Only one destruction code may be reported for the treatment of a specific lesion during the same encounter.

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When both cryosurgical and other destruction methods are used, report lesion counts separately for each method.

- ~~17000~~ Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
- 17X05 Destruction, cryosurgery, premalignant lesions (eg, actinic keratoses); first lesion
(Do not report 17X05 in conjunction with 17X02)
- ✚●17X01 second through 14 lesions, each (List separately in addition to code for primary procedure)
(Use 17X01 in conjunction with 17X05)
(Do not report 17X01 in conjunction with 17X02)
(For destruction of benign lesions, see 17110, 17111)
- 17X02 Destruction, cryosurgery, premalignant lesions (eg, actinic keratoses), 15 or more lesions
(Do not report 17X02 in conjunction with 17X05, 17X01, 17X06, 17X07, 17X03)
(For destruction of benign lesions, see 17110, 17111)
- ✚17003 second through 14 lesions, each (List separately in addition to code for first lesion)
(Use 17003 in conjunction with 17000)
(For destruction of common or plantar warts, see 17110, 17111)
- 17X06 Destruction, (other than cryosurgery monotherapy), (eg, laser surgery, electrosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
(Do not report 17X06 in conjunction with 17X03)
(For destruction of benign lesions, see 17110, 17111)
- ~~17004~~ Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions
(Do not report 17004 in conjunction with 17000–17003)

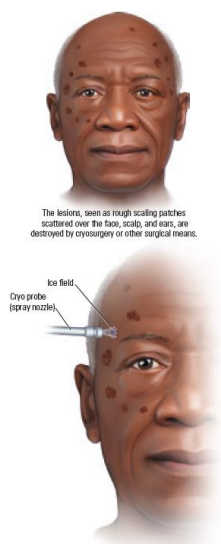
Destruction, Benign or Premalignant Lesions

~~17004~~17X07

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- ➦●17X07 second through 14 lesions, each (List separately in addition to code for primary procedure)

(Use 17X07 in conjunction with ~~17X01, 17X06~~)

(Do not report 17X07 in conjunction with ~~17X05, 17X02, 17X03~~)

(Do not report 17X07 in conjunction with ~~17X05, 17X02, 17X06, 17X03~~)

(For destruction of benign lesions, see 17110, 17111)

- 17X03 Destruction, (other than cryosurgery monotherapy), (eg, laser surgery, electrosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses) 15 or more lesions

(Do not report 17X03 in conjunction with ~~17X06, 17X07~~)

(Do not report 17X03 with ~~17X05, 17X01, 17X02, 17X06, 17X07~~)

(For destruction of benign lesions, see 17110, 17111)

Eye and Ocular Adnexa

Ocular Adnexa

Eyelids

Excision, Destruction

Codes for removal of lesion include more than skin (ie, involving lid margin, tarsus, and/or palpebral conjunctiva).

(For removal of lesion, involving mainly skin of eyelid, see 11310-11313, 11440-11446, 11640-11646, ~~17000-17004~~~~17X05~~, 17X01, 17X02, 17X06, 17X07, 17X03)

(For repair of wounds, blepharoplasty, grafts, reconstructive surgery, see 67930-67975)

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67800 *Excision of chalazion; single*

Medicine

Special Dermatological Procedures

96920 *Excimer laser treatment for psoriasis; total area less than 250 sq cm*

96921 *250 sq cm to 500 sq cm*

96922 *over 500 sq cm*

(For laser destruction of premalignant lesions, see 17000-17004, 17X05, 17X01, 17X02, 17X06, 17X07, 17X03)

(For laser destruction of cutaneous vascular proliferative lesions, see 17106-17108)

(For laser destruction of benign lesions, see 17110-17111)

(For laser destruction of malignant lesions, see 17260-17286)

Typical Patient (17X05)

A 76-year-old male presents with a rough, scaly lesion on his face. Diagnosis of actinic keratosis is made based on history and clinical findings.

Typical Patient (17X01)

A 76-year-old male presents with several rough, scaly lesions on his face and scalp. Diagnosis of actinic keratosis is made based on history and clinical findings. [**Note:** This is an add-on code. Only consider the additional physician work related to for each individual lesion treated.]

Typical Patient (17X02)

A 76-year-old male presents with 15 or greater rough, scaly lesions scattered over his head, neck, upper torso, and extremities. Diagnosis of actinic keratosis is made based on history and clinical findings.

Typical Patient (17X06)

A 76-year-old male presents with a hyperkeratotic and/or recurrent/persistent scaly lesion on his face. Diagnosis of actinic keratosis is made based on history and clinical findings.

Typical Patient (17X07)

A 76-year-old male presents with several hyperkeratotic and/or recurrent/persistent scaly lesions on his face and scalp. Diagnosis of actinic keratosis is made based on history and clinical findings. [**Note:** This is an add-on code. Only consider the additional physician work related to the additional second through 14 to each individual lesions treated.]

Typical Patient (17X03)

A 76-year-old male presents with 15 or greater hyperkeratotic and/or recurrent/persistent scaly lesions scattered over his head, neck, upper torso, and extremities. Diagnosis of actinic keratosis is made based on history and clinical findings.

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Tab 8-Fractional Ablative Laser Services-Hypertrophic Burn

This action will be effective in the CPT 2028 code set.

The Panel accepted this request to: (1) add and delete parenthetical notes following the guidelines under Excision—Benign Lesions, Burns, Local Treatment and Destruction subsections of the code book; (2) establish new guidelines under Other Procedures subsection of the code book; (3) establish eight Category I codes 17XX0, 17XX1, 17XX2, 17XX3, 17XX4, 17XX5, 17XX6, 17XX7 reporting fractional ablative laser treatment of traumatic hypertrophic burn, traumatic, and/or postoperative scar(s); (4) add instructional, inclusionary and exclusionary parenthetical notes following the new codes to direct users appropriate reporting of the new codes; (5) delete Category III codes 0479T, 0480T and corresponding parenthetical notes; and (6) add parenthetical notes to inform users of the deleted codes and instructional parenthetical notes to direct users appropriate reporting of the new codes.

Category I

Surgery

Integumentary System

Skin, Subcutaneous, and Accessory Structures

Excision—Benign Lesions

Excision (including simple closure) of benign lesions of skin (eg, neoplasm, cicatricial, fibrous, inflammatory, congenital, cystic lesions), includes local anesthesia. See appropriate size and area below. For shave removal, see 11300 et seq, and for destruction electro-surgical and other methods see ~~17000~~ 17X05 et seq.

Excision is defined as full-thickness...

The closure of defects created by incision...

(For destruction [eg, laser surgery, electro-surgery, cryosurgery, chemosurgery, surgical curettement] of benign lesions other than skin tags or cutaneous vascular proliferative lesions, see 17110, 17111; premalignant lesions, see ~~17000, 17003, 17004~~ 17X05, 17X01, 17X02, 17X06, 17X07, 17X03; cutaneous vascular proliferative lesions, see 17106, 17107, 17108; malignant lesions, see 17260-17286)

(For excision of cicatricial lesion[s] [eg, full thickness excision, through the dermis], see 11400-11446)

(For incisional removal of burn scar, see 16035, 16036)

(For fractional ablative laser fenestration for functional improvement of traumatic or burn scars, see 0479T, 0480T)

(For fractional ablative laser treatment for hypertrophic burn, traumatic, and/or postoperative scar[s], see 17XX0, 17XX1, 17XX2, 17XX3, 17XX4, 17XX5, 17XX6, 17XX7)

Repair (Closure)

Burns, Local Treatment

Procedures 16000-16036 refer to local treatment of burned surface only. Codes 16020-16030 include the application of materials (eg, dressings) not described in codes 15100-15278.

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List percentage of body surface involved and depth of burn.

*For necessary related medical services (eg, hospital visits, detention) in management of burned patients, see appropriate services in **Evaluation and Management and Medicine** sections.*

For the application of skin grafts or skin substitutes, see codes 15100-15777.

~~(For fractional ablative laser fenestration for functional improvement of traumatic or burn scars, see 0479T, 0480T)~~

(For fractional ablative laser treatment for hypertrophic burn, traumatic, and/or postoperative scar[s], see 17XX0, 17XX1, 17XX2, 17XX3, 17XX4, 17XX5, 17XX6, 17XX7)

Destruction

Destruction means the ablation of benign, premalignant or malignant tissues by any method, with or without curettement, including local anesthesia, and not usually requiring closure.

Any method includes cryosurgery, laser surgery, electrosurgery, chemosurgery, surgical curettement, or a combination of any modalities. Lesions include condylomata, papillomata, molluscum contagiosum, herpetic lesions, warts (ie, common, plantar, flat), milia, or other benign, premalignant (eg, actinic keratoses), or malignant lesions

(For destruction of lesion(s) in specific anatomic sites, see 40820, 46900-46917, 46924, 54050-54057, 54065, 56501, 56515, 57061, 57065, 67850, 68135)

(For laser treatment for inflammatory skin disease, see 96920-96922)

(For paring or cutting of benign hyperkeratotic lesions (eg, corns or calluses), see 11055-11057)

(For sharp removal or electrosurgical destruction of skin tags and fibrocutaneous tags, see 11200, 11201)

(For cryotherapy of acne, use 17340)

(For initiation or follow-up care of topical chemotherapy (eg, 5-FU or similar agents), see appropriate office visits)

(For shaving of epidermal or dermal lesions, see 11300- 11313)

(For excision of cicatricial lesion[s] [eg, full thickness excision, through the dermis], see 11400-11446)

(For incisional removal of burn scar, see 16035, 16036)

~~(For fractional ablative laser fenestration for functional improvement of traumatic or burn scars, see 0479T, 0480T)~~

(For fractional ablative laser treatment for hypertrophic burn, traumatic, and/or postoperative scar[s], see 17XX0, 17XX1, 17XX2, 17XX3, 17XX4, 17XX5, 17XX6, 17XX7)

Other Procedures

Fractional ablative laser treatment for a hypertrophic scar-burn, traumatic, and/or postoperative scar(s)

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uses pixelated ablative laser energy to improve scar thickness, pliability, functional impairment, and/or symptoms such as pain and itch.

Codes 17XX0, 17XX1, 17XX2, 17XX3, 17XX4, 17XX5, 17XX6, 17XX7 are reported for fractional ablative laser treatment for hypertrophic burn, traumatic, and/or postoperative scar(s) based on the anatomic location and total scar surface area treated. For multiple scars, sum the surface area of all scars from all anatomic sites that are grouped together into the same code descriptor. For example, sum the surface area of all scars on the trunk and arms. Do not sum scars from different groupings of anatomic sites (eg, face and arms).

Codes 17XX0, 17XX1, 17XX4, 17XX5 are reported when the total square centimeters of scar(s) treated is less than 100 sq cm per anatomic area.

Codes 17XX2, 17XX3, 17XX6, 17XX7 are reported when the total square centimeters of scar(s) treated is 100 sq cm or greater per anatomic area.

Scar treatment involving the wrist and/or ankle is reported with codes that include arm or leg in the descriptor.

The following definition should be applied to those codes that reference 100 sq cm or 1% of body area of infants and children when determining the involvement of body size: The measurement of 100 sq cm is applicable to adults and children 10 years of age and older; percentages of body surface area apply to infants and children younger than 10 years of age. The measurements apply to the size of the treatment area.

When services are performed in the office, routine dressing supplies are not reported separately.

17380 Electrolysis epilation, each 30 minutes

(For actinotherapy, use 96900)

- 17XX0 Fractional ablative laser treatment of hypertrophic burn, traumatic, and/or postoperative scar(s), trunk, arms, and/or legs, total scar surface area up to 100 sq cm; first 25 sq cm or less scar surface area
- +●17XX1 each additional 25 sq cm scar surface area, or part thereof (List separately in addition to code for primary procedure)
(Use 17XX1 in conjunction with 17XX0)
(Do not report 17XX0, 17XX1 in conjunction with 17XX2, 17XX3)
(For total scar surface area greater than or equal to 100 sq cm, see 17XX2, 17XX3, 17XX6, 17XX7)
- 17XX2 Fractional ablative laser treatment of hypertrophic burn, traumatic, and/or postoperative scar(s), trunk, arms, and/or legs, total scar surface area greater than or equal to 100 sq cm; first 100 sq cm scar surface area, or 1% of body surface area of infants and children
- +●17XX3 each additional 100 sq cm scar surface area, or part thereof, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)

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(Use 17XX3 in conjunction with 17XX2)

(For total scar surface area up to 100 sq cm, see 17XX0, 17XX1, 17XX4, 17XX5)

- 17XX4 Fractional ablative laser treatment of hypertrophic burn, traumatic, and/or postoperative scar(s), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total scar surface area up to 100 sq cm; first 25 sq cm or less scar surface area

- ✚●17XX5 each additional 25 sq cm scar surface area, or part thereof (List separately in addition to code for primary procedure)

(Use 17XX5 in conjunction with 17XX4)

(Do not report 17XX4, 17XX5 in conjunction with 17XX6, 17XX7)

(For total scar surface area greater than or equal to 100 sq cm, see 17XX2, 17XX3, 17XX6, 17XX7)

- 17XX6 Fractional ablative laser treatment of hypertrophic burn, traumatic, and/or postoperative scar(s), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total scar surface area greater than or equal to 100 sq cm; first 100 sq cm scar surface area, or 1% of body surface area of infants and children

- ✚●17XX7 each additional 100 sq cm scar surface area, or part thereof, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)

(Use 17XX7 in conjunction with 17XX6)

(For total scar surface area up to 100 sq cm, see 17XX0, 17XX1, 17XX4, 17XX5)

Category III Codes

- ~~0479T Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm² or part thereof, or 1% of body surface area of infants and children~~

- ~~✚0480T each additional 100 cm², or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)~~

~~(Use 0480T in conjunction with 0479T)~~

~~(Report 0479T, 0480T only once per day)~~

~~(For excision of cicatricial lesion[s] [eg, full thickness excision, through the dermis], see 11400-11446)~~

~~(0479T, 0480T have been deleted)~~

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(For fractional ablative laser treatment for hypertrophic burn, traumatic, and/or postoperative scar[s], see 17XX0, 17XX1, 17XX2, 17XX3, 17XX4, 17XX5, 17XX6, 17XX7)

Typical Patient (17XX0)

A 40-year-old female with symptomatic hypertrophic scars on her dorsal right wrist and forearm presents for treatment. The involved scar surface area to be treated is less than 100 sq cm. The first 25 sq cm of scar is treated with a fractional ablative laser.

Typical Patient (17XX1)

A 40-year-old female with symptomatic hypertrophic scars on her dorsal right wrist and forearm presents for treatment. The involved scar surface area to be treated is less than 100 sq cm. After fractional ablative laser treatment of the first 25 sq cm (reported separately), an additional 25 sq cm of scar is treated. [Note: This is an add-on code. Only consider the additional physician work related to the additional 25 sq cm of treatment.]

Typical Patient (17XX2)

A 34-year-old male with symptomatic hypertrophic scars on his chest, left shoulder, left axilla, and left upper arm presents for treatment. The involved total scar surface area to be treated is greater than 100 sq cm. The first 100 sq cm of scar is treated with a fractional ablative laser.

Typical Patient (17XX3)

A 34-year-old male with symptomatic hypertrophic scars on his chest, left shoulder, left axilla, and left upper arm presents for treatment. The involved total scar surface area to be treated is greater than 100 sq cm. After fractional ablative laser treatment of the first 100 sq cm (reported separately), an additional 100 sq cm of scar is treated. [Note: This is an add-on code. Only consider the additional physician work related to the additional 100 sq cm of treatment.]

Typical Patient (17XX4)

A 38-year-old male with symptomatic hypertrophic scars on the dorsal side of his right hand presents for treatment. The involved scar surface area to be treated is less than 100 sq cm. The first 25 sq cm of scar is treated with a fractional ablative laser.

Typical Patient (17XX5)

A 38-year-old male with symptomatic hypertrophic scars on the dorsal side of his right hand presents for treatment. The involved scar surface area to be treated is less than 100 sq cm. After fractional ablative laser treatment of the first 25 sq cm (reported separately), an additional 25 sq cm of scar is treated. [Note: This is an add-on code. Only consider the additional physician work related to the additional 25 sq cm of treatment.]

Typical Patient (17XX6)

A 42-year-old female with symptomatic hypertrophic scars on her face and neck presents for treatment. The involved total scar surface area to be treated is greater than 100 sq cm. The first 100 sq cm of scar is treated with a fractional ablative laser.

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Typical Patient (17XX7)

A 42-year-old female with symptomatic hypertrophic scars on her face and neck presents for treatment. The involved total scar surface area to be treated is greater than 100 sq cm. After fractional ablative laser treatment of the first 100 sq cm (reported separately), an additional 100 sq cm of scar is treated. [Note: This is an add-on code. Only consider the additional physician work related to the additional 100 sq cm of treatment.]

Tab 9-Cryoablation-Breast Tumor

The Panel rejected this request to delete Category III code [0581T] and establish Category I code 191XX to report percutaneous, cryosurgical ablation, of malignant breast tumor tissue.

As rationale for rejection of this request, the Panel noted that the following CPT Criteria have not been met:

Specific Criteria For Category I:

C5. The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code-change application.

Tab 10-Hepatic Artery Infusion Pump Service

This action will be effective in the CPT 2028 code set.

Tab 10 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted Option C of this request to: (1) revise code 36260 to describe open implantation of hepatic intra-arterial infusion pump and to replace chemotherapy of liver with direct hepatic artery chemotherapy infusion in the list of examples; (2) revise codes 36261 (revision) and 36262 (removal) to specify the procedure is performed via either open, laparoscopic, or robotic approach, and to specify *hepatic* intra-arterial infusion pump; (3) establish code 377X0 to report laparoscopic implantation of hepatic intra-arterial infusion pump; (4) add a cross-reference parenthetical note following code 36260 directing to code 377X0; and (5) add cross-reference parenthetical notes following code 377X0 directing to codes 36260, 36261, and 36262.

Category I

Surgery

Cardiovascular System

Arteries and Veins

Vascular Injection Procedures

Intra-Arterial—Intra-Aortic

▲36260 ~~Insertion-Implantation, open, of implantable hepatic intra-arterial infusion pump (eg, for direct hepatic artery chemotherapy infusion for chemotherapy of liver)~~

(For laparoscopic implantation of a hepatic intra-arterial infusion pump, use 377X0)

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▲36261 Revision, ~~any method (ie, open, laparoscopic, robotic),~~ of implanted hepatic intra-arterial infusion pump, via open, laparoscopic, or robotic approach

▲36262 Removal, ~~any method (ie, open, laparoscopic, robotic),~~ of implanted hepatic intra-arterial infusion pump, via open, laparoscopic, or robotic approach

Other Procedures

●377X0 Laparoscopy, surgical, with implantation of hepatic intra-arterial infusion pump (eg, for direct hepatic artery chemotherapy)

(For open implantation of a hepatic intra-arterial infusion pump, use 36260)

(For open, laparoscopic, or robotic revision or removal of a hepatic implanted intra-arterial infusion pump, see 36261, 36262)

37799 *Unlisted procedure, vascular surgery*

Typical Patient ([36260])

A 55-year-old male with synchronous rectal cancer and unresectable liver metastases, with a history of multiple prior abdominal operations, undergoes open placement of a hepatic artery infusion (HAI) pump.

Typical Patient ([36261])

A 55-year-old male with a hepatic artery infusion pump develops a pump pocket infection and undergoes revision with resiting of the pump.

Typical Patient ([36262])

A 55-year-old male who has completed adjuvant therapy via a hepatic artery infusion pump undergoes removal of the pump.

Typical Patient (377X0)

A 55-year-old male with synchronous rectal cancer and unresectable liver metastases undergoes minimally invasive (ie, laparoscopic/robotic) placement of a hepatic artery infusion pump.

Tab 11-Percutaneous US Fragmentation and Aspiration-Elbow-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 12-Subtalar Sinus Tarsi Stabilization-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 13-Posterior Vertebral Column Arthroplasty

This action will be effective in the CPT 2028 code set.

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Tab 13 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted Option B of this request to: (1) delete Category III code 0202T and its associated exclusionary parenthetical note, add a new subheading titled Spinal Prosthetic Devices in the Spinal Instrumentation subsection, and establish Category I codes 22XX1, 22XX2 to report posterior vertebral column arthroplasty with insertion of a posterior prosthetic arthroplasty device (22XX1) and posterior vertebral column arthroplasty revision (22XX2) with included services; (2) add a new cross reference parenthetical note following 22XX1 directing users to the appropriate codes for reporting posterior vertebral joint replacement (0719T), and following deleted code 0202T and 0719T to direct users to codes 22XX1, 22XX2 for posterior vertebral column arthroplasty procedures; (3) add exclusionary parenthetical notes following codes 22XX1, 22XX2; and (4) revise an exclusionary parenthetical note following 0719T to include 22XX1, 22XX2 and restrict reporting these services in conjunction with procedures that include work that is already included within the described services.

Category I
Surgery
Musculoskeletal System
Spine (Vertebral Column)
Spinal Instrumentation

22869 *Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level*

+22870 *second level (list separately in addition to code for primary procedure)*
(Use 22870 in conjunction with 22869)
(Do not report 22869, 22870 in conjunction with 22532, 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634, 22800, 22802, 22804, 22840, 22841, 22842, 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047, 63048, 77003)

Spinal Prosthetic Devices (Blue Heading)

- 22XX1 Posterior vertebral column arthroplasty, including decompression, facetectomy, laminectomy, and foraminotomy, and facetectomy, with insertion of a posterior prosthetic arthroplasty device, including image-imaging guidance and harvest and insertion of free fat graft, single segment, lumbar
(Do not report 22XX1 in conjunction with 22214, 22511, 22514, 22840, 22853, 22854, 22857, 22859, 63005, 63012, 63017, 63030, 63042, 63047, 63056 at the same level)
(For posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment, use [0719T])
- 22XX2 Revision, including replacement, posterior vertebral column arthroplasty, posterior approach, including imaging guidance, harvest and insertion of free fat graft, single segment, lumbar

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(Do not report 22XX2 in conjunction with 22214, 22511, 22514, 22840, 22853, 22854, 22857, 22859, 63005, 63012, 63017, 63030, 63042, 63047, 63056 at the same level)

Category III Codes

- ~~0202T~~ ~~Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine~~
~~(Do not report 0202T in conjunction with 22511, 22514, 22840, 22853, 22854, 22857, 22859, 63005, 63012, 63017, 63030, 63042, 63047, 63056 at the same level)~~
~~(0202T has been deleted)~~
~~(For posterior vertebral column arthroplasty [eg, facet segment{s} replacement], posterior approach, including laminectomy and foraminotomy [for decompression], and facetectomy, with insertion of posterior vertebral column fixation device, including imaging guidance, see 22XX1, 22XX2)~~
~~(For intravascular catheter-based coronary vessel or graft spectroscopy [eg, infrared] during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation, and report, each vessel, use 93799)~~
~~(For computerized database analysis of multiple cycles of digitized cardiac electrical data from 2 or more ECG leads, including transmission to a remote center, application of multiple nonlinear mathematical transformations, with coronary artery obstruction severity assessment, use 93799)~~
- 0719T *Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment*
(Do not report 0719T in conjunction with 22840, 22XX1, 22XX2, 63005, 63012, 63017, 63030, 63042, 63047, 63056, 76000, 76496)
(For posterior vertebral column arthroplasty [eg, facet segment{s} replacement], posterior approach, including laminectomy and foraminotomy [for decompression], and facetectomy, with insertion of posterior vertebral column fixation device, including imaging guidance, see 22XX1, 22XX2)

Typical Patient (22XX1)

A 67-year-old male ~~with~~ has symptomatic single-level lumbar spinal stenosis including leg radiculopathy and back pain associated with ~~Grade I degenerative spondylolisthesis after failure of appropriate nonoperative treatment~~ grade 1 degenerative L4/L5 spondylolisthesis, ~~causing leg radiculopathy with some back pain. Conservative treatments have been exhausted and failed.~~ Imaging demonstrates severe spinal stenosis at L4 and L5. ~~To preserve motion post-intervention, the~~ The physician orders performs a posterior vertebral column arthroplasty.

Typical Patient (22XX2)

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A 62-year-old female presents status post posterior vertebral column arthroplasty several days ago. Follow-up X-rays show mechanical dysfunction of the device requiring revision.

Tab 14-Disc Arthroplasty Code 22860 Parenthetical Note Revision

This action will be effective in the CPT 2028 code set.

Tab 14 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted this request to add an instructional parenthetical note following Category I add-on code 22860 to clarify that each additional level should be reported using the unlisted procedure (22899).

Category I

Surgery

Musculoskeletal System

Spine (Vertebral Column)

Spinal Instrumentation

22857 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar*
(Do not report 22857 in conjunction with 22558, 22845, 22853, 22854, 22859, 49010 when performed at the same level)

✚22860 *second interspace, lumbar (List separately in addition to code for primary procedure)*
(Use 22860 in conjunction with 22857)
(For total disc arthroplasty, anterior approach, lumbar, ~~more than two interspaces~~, use 22899 for third and additional levels)

Tab 15-SI Joint Injection

This action will be effective in the CPT 2028 code set.

The Panel accepted with modifications on-site Option D of this request to: (1) add a cross-reference parenthetical note following code 27096 directing users to code 27299; and (2) delete a cross-reference parenthetical note following code 27096 that directed users to 20552.

The Panel modified this request by deleting the term “fluoroscopy” and adding “fluoroscopic guidance” to the instructional parenthetical following code 27096.

Category I

Surgery

Musculoskeletal System

Pelvis and Hip Joint

Introduction or Removal

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27096 *Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed*
(27096 is to be used only with CT or fluoroscopic imaging confirmation of intra-articular needle positioning)
(If CT or fluoroscopy imaging is not performed, use 20552)
(For sacroiliac joint injection without CT or fluoroscopic guidance, use 27299)
(Code 27096 is a unilateral procedure. For bilateral procedure, use modifier 50)

Tab 16-Endoscopic Ablation-Posterior Nasal Nerve-Rev 31242-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 17-Substernal Implantable Cardioverter-Defib Procedures

The Panel rejected this request to: (1) delete Category III codes 0571T-0580T, 0614T; (2) add a new subheading; (3) add Category I codes 332X1, 332X2, 332X3, and 332X4 to report insertion/replacement of an implantable cardioverter-defibrillator with substernal electrode; and (4) revise Category I codes 93260, 93261, 93644 and all related guidelines and parenthetical notes.

As rationale for rejection of this request, the Panel noted that the following CPT Criteria have not been met:

Specific Criteria For Category I:

C5. The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code-change application.

Tab 18-Transcatheter Mitral Valve Replacement (TMVR)

This action will be effective in the CPT 2028 code set.

The Panel accepted with modifications Option B of this request to: (1) *editorially* revise codes 33418, 33419, and 0345T with the addition of the acronym “TMVr”; (2) establish code 33XX0 for reporting percutaneous transcatheter mitral valve replacement (TMVR) with prosthetic valve, including transseptal puncture when performed; (3) add guidelines to the Cardiac Valves subsection that clarify the distinction between valve repair and valve replacement; (4) revise parenthetical notes throughout the code set with replacement of code 0483T with 33XX0; (5) revise Mitral Valve subsection guidelines by (a) adding definitions for TMVr and TMVR; (b) adding clarifying language about the appropriate reporting of code 33XX0; and (c) revising the language to refer to “TMVr or TMVR”; (6) revise the guidelines for code 0345T to clarify 0345T is used to report TMVr performed via the coronary sinus; (7) delete Category III code 0483T and associated parenthetical notes and guidelines; (8) add a cross-reference parenthetical note directing to code 33XX0 for percutaneous transcatheter TMVR; (9) *editorially* revise Category III code

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0484T with the removal of “implantation” and replacing “TMVI” with “TMVR”; (10) revise the 0484T guidelines to clarify 0484T is used to report TMVR and encompasses all associated procedural components, and to reflect the deletion of code 0483T; (11) add cross-reference parenthetical notes following code 0484T directing users to codes 0544T, 33418, 33419, and 0345T; and (12) revise the 0484T typical patient and description of procedure.

The Panel modified the request by: (1) revising the exclusionary parenthetical note following code 33418 by removing “unless transapical puncture is performed”; (2) adding an exclusionary parenthetical note following 33XX0 restricting reporting of 33XX0 with codes 92987 and 93462; and (3) revising the 33XX0 typical patient by replacing the sentence, “Upon evaluation, it is determined that he is an appropriate candidate for transcatheter mitral valve replacement” with “Transcatheter mitral valve replacement is performed.”

Category I
Surgery
Cardiovascular System
Heart and Pericardium
Cardiac Valves

For the purposes of reporting aortic and mitral valve repair and replacement: (1) valve repair refers to preservation and modification of the native valve to restore function; and (2) valve replacement refers to implantation of a prosthetic valve to assume native valve function. Implantation of the prosthetic valve is inherent in the replacement.

(For multiple valve procedures, see 33390, 33391, 33404-33478 and add modifier 51 to the secondary valve procedure code)

Aortic Valve

33361 *Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach*

...

✚33367 *cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)*

(Use 33367 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33477, ~~0483T~~ 33XX0, 0484T, 0544T, 0545T, 0569T, 0570T, 0643T, 0644T)

(Do not report 33367 in conjunction with 33368, 33369)

(For cerebral embolic protection, use 33370)

✚33368 *cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)*

(Use 33368 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33477, ~~0483T~~ 33XX0, 0484T, 0544T, 0545T, 0569T, 0570T, 0643T, 0644T)

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(Do not report 33368 in conjunction with 33367, 33369)

+33369 *cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)*

(Use 33369 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33477, ~~0483T~~ 33XX0, 0484T, 0544T, 0545T, 0569T, 0570T, 0643T, 0644T)

(Do not report 33369 in conjunction with 33367, 33368)

Mitral Valve

Transcatheter mitral valve repair (TMVr): Preservation and modification of the native valve to restore function.

Transcatheter mitral valve replacement (TMVR): Insertion (ie, implantation) of a prosthetic valve to assume native valve function. The term “implantation” should be understood as the act of placing the prosthetic valve and treated as inherently included within replacement, not as separate clinical category, unless CPT explicitly defines a distinct meaning.

Codes 33418 and 33419 are used to report transcatheter mitral valve repair (TMVr). Code 33419 should only be reported once per session. Code 33XX0 is used to report transcatheter mitral valve replacement (TMVR).

Codes 33418 and 33419 include the work, when performed, of percutaneous access, placing the access sheath, transseptal puncture, advancing the repair device delivery system into position, repositioning the device as needed, and deploying the device(s). Code 33XX0 includes vascular access, catheterization, balloon valvuloplasty, deploying the valve, repositioning the valve as needed, temporary pacemaker insertion for rapid pacing, and access site closure, when performed.

Angiography, radiological supervision, and interpretation performed to guide TMVr (eg, guiding device placement and documenting completion of the intervention) are included in ~~these codes 33418, 33419.~~ Code 33XX0 includes angiography, radiological supervision and interpretation, intraprocedural roadmapping (eg, contrast injections, fluoroscopy) to guide the TMVR, left ventriculography (eg, to access mitral regurgitation) for guidance of TMVR, and completion angiography.

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 33418, 33419, 33XX0 to report:

1. Contrast injections, angiography, road-mapping, and/ or fluoroscopic guidance for the ~~transcatheter mitral valve repair (TMVr or TMVR),~~
2. Left ventricular angiography to assess mitral regurgitation for guidance of TMVr or TMVR, or
3. Right and left heart catheterization for hemodynamic measurements before, during, and after TMVr or TMVR for guidance ~~of TMVR.~~

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

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(93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564) may be reported with 33418, 33419, 33XX0 representing separate and distinct services from TMVr or TMVR, 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:
 1. There is inadequate visualization of the anatomy and/or pathology, or
 2. The patient's condition with respect to the clinical indication has changed since the prior study, or
 3. There is a clinical change during the procedure that requires new evaluation.

Other cardiac catheterization services may be reported separately when performed for diagnostic purposes not intrinsic to TMVr or TMVR.

For same session/same day diagnostic cardiac catheterization services, report the appropriate diagnostic cardiac catheterization code(s) appended with modifier 59 indicating separate and distinct procedural service from TMVr or TMVR.

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

When cardiopulmonary bypass is performed in conjunction with TMVr or TMVR, 33418, 33419, 33XX0 may be reported with the appropriate add-on code for percutaneous peripheral bypass (33367), open peripheral bypass (33368), or central bypass (33369).

- ▲33418 Transcatheter mitral valve repair (TMVr), percutaneous approach, including transseptal puncture when performed; initial prosthesis
(Do not report 33418 in conjunction with 93462 ~~unless transapical puncture is performed~~)
- ✚▲33419 additional prosthesis(es) during same session (List separately in addition to code for primary procedure)
(Use 33419 in conjunction with 33418)
(For transcatheter mitral valve repair, percutaneous approach via the coronary sinus, use 0345T)
(For transcatheter mitral valve ~~implantation~~/replacement [TMVr] by transthoracic exposure, see 0483T, 0484T)
(For transcatheter mitral valve annulus reconstruction, use 0544T)
- 33XX0 Transcatheter mitral valve replacement (TMVR) with prosthetic valve, percutaneous approach, including transseptal puncture, when performed
(Do not report 33XX0 in conjunction with 92987, 93462)

Medicine

Cardiovascular

Cardiac Catheterization

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- 93451 *Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed*
(Do not report 93451 in conjunction with 33289, 93453, 93456, 93457, 93460, 93461, 0613T, 0632T)
(Do not report 93451 in conjunction with 33418, 33XX0, 0345T, ~~0483T~~, 0484T, 0544T, 0545T, 0643T, for diagnostic right heart catheterization procedures intrinsic to the valve repair, annulus reconstruction procedure, or left ventricular restoration device implantation)
- 93452 *Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed*
(Do not report 93452 in conjunction with 93453, 93458-93461, 0408T, 0409T, 0410T, 0411T, 0414T, 0415T)
(Do not report 93452 in conjunction with 33418, 33XX0, 0345T, ~~0483T~~, 0484T, 0544T, 0545T, 0643T, for diagnostic left heart catheterization procedures intrinsic to the valve repair, annulus reconstruction procedure, or left ventricular restoration device implantation)
- 93453 *Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed*
(Do not report 93453 in conjunction with 93451, 93452, 93456-93461, 0408T, 0409T, 0410T, 0411T, 0414T, 0415T)
(Do not report 93453 in conjunction with 33418, 33XX0, 0345T, ~~0483T~~, 0484T, 0544T, 0545T, 0643T, for diagnostic left and right heart catheterization procedures intrinsic to the valve repair, annulus reconstruction procedure, or left ventricular restoration device implantation)
- 93454 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation*
(Do not report 93454 in conjunction with 33418, 33XX0, 0345T, ~~0483T~~, 0484T, 0544T, 0545T, 0643T, for coronary angiography intrinsic to the valve repair, annulus reconstruction procedure, or left ventricular restoration device implantation)
- 93455 *with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography*
(Do not report 93455 in conjunction with 33418, 33XX0, 0345T, ~~0483T~~, 0484T, 0544T, 0545T, 0643T, for coronary angiography intrinsic to the valve repair, annulus reconstruction procedure, or left ventricular restoration device implantation)
- 93456 *with right heart catheterization*

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(Do not report 93456 in conjunction with 33418, 33XX0, 0345T, ~~0483T~~, 0484T, 0544T, 0545T, 0643T, for diagnostic coronary angiography or right heart catheterization procedures intrinsic to the valve repair, annulus reconstruction procedure, or left ventricular restoration device implantation)

93457 *with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization*

(Do not report 93457 in conjunction with 33418, 33XX0, 0345T, ~~0483T~~, 0484T, 0544T, 0545T, 0643T, for diagnostic coronary angiography or right heart catheterization procedures intrinsic to the valve repair, annulus reconstruction procedure, or left ventricular restoration device implantation)

93458 *with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed*

(Do not report 93458 in conjunction with 33418, 33XX0, 0345T, ~~0483T~~, 0484T, 0544T, 0545T, 0643T, for diagnostic coronary angiography or left heart catheterization procedures intrinsic to the valve repair, annulus reconstruction procedure, or left ventricular restoration device implantation)

(Do not report 93458 in conjunction with 0408T, 0409T, 0410T, 0411T, 0414T, 0415T)

93459 *with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography*

(Do not report 93459 in conjunction with 33418, 33XX0, 0345T, ~~0483T~~, 0484T, 0544T, 0545T, 0643T, for diagnostic coronary angiography or left heart catheterization procedures intrinsic to the valve repair, annulus reconstruction procedure, or left ventricular restoration device implantation)

(Do not report 93459 in conjunction with 0408T, 0409T, 0410T, 0411T, 0414T, 0415T)

93460 *with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed*

(Do not report 93460 in conjunction with 33418, 33XX0, 0345T, ~~0483T~~, 0484T, 0544T, 0545T, 0643T, for diagnostic coronary angiography or left and right heart catheterization procedures intrinsic to the valve repair, annulus reconstruction procedure, or left ventricular restoration device implantation)

(Do not report 93460 in conjunction with 0408T, 0409T, 0410T, 0411T, 0414T, 0415T)

93461 *with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography*

(Do not report 93461 in conjunction with 33418, 33XX0, 0345T, ~~0483T~~, 0484T, 0544T, 0545T, 0643T, for diagnostic coronary angiography or left and right heart catheterization

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procedures intrinsic to the valve repair, annulus reconstruction procedure, or left ventricular restoration device implantation)

(Do not report 93461 in conjunction with 0408T, 0409T, 0410T, 0411T, 0414T, 0415T)

+93462

Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)

(Use 93462 in conjunction with 33477, 33741, 33745, 93452, 93453, 93458, 93459, 93460, 93461, 93582, 93595, 93596, 93597, 93653, 93654)

(Use 93462 in conjunction with 93590, 93591 for transapical puncture performed for left heart catheterization and percutaneous transcatheter closure of paravalvular leak)

(Use 93462 in conjunction with 93581 for transseptal or transapical puncture performed for percutaneous transcatheter closure of ventricular septal defect)

(Do not report 93462 in conjunction with 93590 for transeptal puncture through intact septum performed for left heart catheterization and percutaneous transcatheter closure of paravalvular leak)

(Do not report 93462 in conjunction with 33418, 33XX0, 93656)

(Do not report 93462 in conjunction with 33418, 0345T, 0544T, unless transapical puncture is performed)

+93563

Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)

(Use 93563 in conjunction with 33741, 33745, 93582, 93593, 93594, 93595, 93596, 93597)

+93564

for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)

(Use 93564 in conjunction with 93582, 93593, 93594, 93595, 93596, 93597)

(Do not report 93563, 93564 in conjunction with 33418, 33XX0, 0345T, ~~0483T~~, 0484T, 0544T, 0545T for coronary angiography intrinsic to the valve repair or annulus reconstruction procedure)

Intracardiac Electrophysiological Procedures/Studies

+93662

Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)

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(Use 93662 in conjunction with 33274, 33275, 33340, 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33477, ~~33XX0~~, 33741, 33745, 92986, 92987, 92990, 92997, 93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93505, 93580, 93581, 93582, 93583, 93590, 93591, 93593, 93594, 93595, 93596, 93597, 93620, 93653, 93654, 0345T, ~~0483T~~, 0484T, 0543T, 0544T, 0545T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0823T, 0824T, 0825T, as appropriate)

Category III Codes

Code 0345T is used to report transcatheter mitral valve repair (TMVr) via the coronary sinus.

Fluoroscopy (76000) and radiologic supervision and interpretation are inherent to the transcatheter mitral valve repair (TMVr~~R~~) procedure and are not separately reportable. Diagnostic cardiac catheterization (93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598) should **not** be reported with transcatheter mitral valve repair (0345T) for:

- Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the transcatheter mitral valve repair (TMVr~~R~~),
- Left ventricular angiography to assess mitral regurgitation for guidance of TMVr~~R~~, or
- Right and left heart catheterization for hemodynamic measurements before, during, and after TMVr~~R~~ for guidance of TMVR.

Diagnostic right and left heart catheterization (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598) and diagnostic coronary angiography (93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564) not inherent to the TMVr~~R~~ may be reported with 0345T, appended with modifier 59, 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.

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

Other cardiac catheterization services may be reported separately, when performed for diagnostic purposes not intrinsic to the TMVr~~R~~.

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

▲0345T Transcatheter mitral valve repair (TMVr), percutaneous approach via the coronary sinus
(For transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed, see 33418, 33419)

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(Do not report 0345T in conjunction with 93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461 for diagnostic left and right heart catheterization procedures intrinsic to the valve repair procedure)

(Do not report 0345T in conjunction with 93453, 93454, 93563, 93564 for coronary angiography intrinsic to the valve repair procedure)

(For transcatheter mitral valve ~~implantation~~/replacement [TMVR], see ~~0483T~~ 33XX0, 0484T)

(For transcatheter mitral valve annulus reconstruction, use 0544T)

...

Codes ~~0483T~~, 0484T is used to report transcatheter mitral valve replacement (TMVR) with transthoracic exposure, and encompasses all associated procedural components, including vascular access, catheterization, balloon valvuloplasty, ~~deployment~~ of the valve, repositioning the valve as needed, temporary pacemaker insertion for rapid pacing, and access site closure, when performed.

Angiography, radiological supervision and interpretation, intraprocedural roadmapping (eg, contrast injections, fluoroscopy) to guide the TMVR, left ventriculography (eg, to assess mitral regurgitation for guidance of TMVR), and completion angiography are included in codes ~~0483T~~, 0484T.

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 ~~0483T~~, 0484T to report:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the ~~transcatheter mitral valve implantation (TMVR)~~,
2. Left ventricular angiography to assess or confirm valve positioning and function,
3. Right and left heart catheterization for hemodynamic measurements before, during, and after TMVR for guidance of TMVR.

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) performed at the time of TMVR may be separately reportable, 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.

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For same session/same day diagnostic cardiac catheterization services, report the appropriate diagnostic cardiac catheterization code(s) appended with modifier 59, indicating separate and distinct procedural service from TMVRI.

When cardiopulmonary bypass is performed in conjunction with TMVRI, 0483T, 0484T may be reported with the appropriate add-on code for percutaneous peripheral bypass (33367), open peripheral bypass (33368), or central bypass (33369).

For percutaneous transcatheter tricuspid valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, use 0545T.

~~0483T Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed~~

~~(For transcatheter mitral valve annulus reconstruction, use 0544T)~~

~~(For transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed, see 33418, 33419)~~

~~(For transcatheter mitral valve repair percutaneous approach via the coronary sinus, use 0345T)~~

~~(0483T has been deleted)~~

~~(For percutaneous transcatheter mitral valve replacement [TMVR] with prosthetic valve including transseptal puncture, when performed, use 33XX0)~~

▲0484T Transcatheter mitral valve ~~implantation/replacement (TMVRI)~~ with prosthetic valve, transthoracic exposure (eg, thoracotomy, transapical)

(For percutaneous transcatheter mitral valve annulus reconstruction with implantation of adjustable annulus reconstruction device including transseptal puncture, use 0544T)

(For percutaneous transcatheter mitral valve repair [TMVr] including transseptal puncture, when performed, see 33418, 33419)

(For percutaneous transcatheter mitral valve repair [TMVr] via the coronary sinus, use 0345T)

Codes 0544T and...

Angiography, radiological supervision...

Diagnostic right and...

Diagnostic right and...

...

Code 0544T is used to report For percutaneous transcatheter mitral valve repair (TMVr) via the coronary sinus, use 0345T. For percutaneous transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve, use 0483T.

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0544T *Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture*
(For transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed, see 33418, 33419)
(For transcatheter mitral valve repair percutaneous approach via the coronary sinus, use 0345T)
(For transcatheter mitral valve implantation/replacement [TMVI] with prosthetic valve percutaneous approach, use 0483T)

Typical Patient (33XX0)

A 72-year-old male presents with severe, symptomatic mitral regurgitation. Prior diagnostic transesophageal echocardiography demonstrated mitral regurgitation with papillary muscle dysfunction and a dilated left ventricle. Transcatheter mitral valve replacement is performed.

REVISED Typical Patient (0484T)

A 78-year-old female with multiple medical problems, including dialysis dependent chronic renal failure, severe chronic obstructive pulmonary disease, and significant coronary artery disease, presents with severe, symptomatic mitral regurgitation presents with . Prior diagnostic transesophageal echocardiography demonstrated mitral regurgitation in the setting of class III-IV heart failure. Prior diagnostic transesophageal echocardiography demonstrated severe mitral regurgitation. In addition, she is also noted to have severe mitral annular calcification and atrial fibrillation thrombus in her left atrial appendage. The patient is referred for transcatheter mitral valve replacement implantation. The heart valve team comprising a cardiac surgeon and an interventional cardiologist, agree that the patient is high risk for open valve surgery. The heart valve team recommends transcatheter mitral valve replacement with transthoracic exposure via thoracotomy and a transapical approach ~~implantation via thoracotomy with a transapical exposure.~~

REVISED Description of Procedure (0484T)

After initiation of general anesthesia, arterial access (eg, femoral) is obtained for reference pigtail catheter placement to obtain left ventriculography, as needed. The heart is exposed through a thoracotomy (eg, fourth, fifth, or sixth intercostal space), and a pericardiotomy is performed. Two circumferential pledgeted purse-string sutures are placed in the apex of the left ventricle, carefully avoiding the coronary vasculature. Anticoagulant therapy is administered to achieve therapeutic anticoagulation levels. ~~A sheath may be introduced into the left ventricle.~~ The pigtail catheter is advanced over a guidewire to inject contrast and obtain a fluoroscopic view of the mitral valve. As situated by the purse-string sutures, a needle is inserted at the apex of the left ventricle followed by a guidewire. The apical dilator and sheath are advanced over the wire and through the left ventricular wall, with small cuts being made as necessary to facilitate insertion. The purse-string sutures are tightened to hold the sheath in place, and the guidewire and apical dilator are removed. The pigtail catheter may be advanced into the left ventricle and contrast injected to obtain a left ventriculogram, noting the position of the native mitral valve. Using wires affixed to the ventricle, rapid ventricular pacing is performed during the ventriculogram. The pigtail catheter may then be withdrawn into the aorta. While managing the apical sheath and under transesophageal

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echocardiography guidance (coded separately when performed by a different physician or other qualified health care professional), the mitral valve delivery catheter is advanced through the sheath and into the left ventricle. The delivery catheter is advanced up through the ventricle and across the mitral valve into the left atrium. The mitral valve prosthesis is positioned in the mitral plane, taking care to minimize the risk to the chordae. Under rapid pacing by a temporary transvenous pacemaker electrode, the transcatheter mitral valve prosthesis is expanded and seated. Fluoroscopy and transesophageal echocardiography are used continuously during deployment to monitor positioning. After deployment of the new valve prosthesis, the degree of regurgitation and resultant gradients are measured and evaluated. After confirmation of proper position and function of the valve by fluoroscopy and transesophageal echocardiography, the delivery catheter is withdrawn, and the purse string sutures are tied to close the apical access. Guidewires and sheaths are removed. A chest tube is placed in the left pleural space and brought out below the wound. The subcutaneous tissues are closed in layers, and the skin incision is closed with a running intracuticular stitch.

Tab 19-Renal Nerve Denervation

This action will be effective in the CPT 2028 code set.

The Panel accepted with modifications this request to: (1) revise the exclusionary parenthetical note following code 36254 by replacing the deleted codes with the new codes; (2) establish a new black header Renal Nerve Denervation in the Transcatheter Procedures subsection; (3) establish guidelines in the new Renal Nerve Denervation subsection; (4) establish two Category I codes 37X47, 37X48 reporting percutaneous transcatheter renal sympathetic denervation; (5) add instructional and exclusionary parenthetical notes regarding appropriate reporting of the new codes; (6) revise the parenthetical note following code 37253 by adding the new codes and deleting code 0338T; (7) delete Category III codes 0338T, 0339T and all corresponding parenthetical notes; (8) add parenthetical notes to inform users of the deleted codes and instructional parenthetical notes to direct users appropriate reporting of the new codes; and (9) revise the exclusionary parenthetical note following 0935T by adding the new codes and deleting code 0339T.

The Panel modified this request by: (1) deleting the term “with” from 37X48; (2) adding an exclusionary parenthetical note following 37X48; and (3) adding the terms “treatment” “greater than” and “160” and deleting the terms “of 168”, “, despite the patient's adherence to a drug regimen involving four medications known to typically reduce and treat hypertension” and “option of renal denervation is discussed with the patient and his family; the” from the typical patient description for 37X47.

Category I

Surgery

Cardiovascular System

Arteries and Veins

Vascular Injection Procedures

Intra-Arterial—Intra-Aortic

36253 *Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography,*

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including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

(Do not report 36253 in conjunction with 36251 when performed for the same kidney)

36254 *bilateral*

(Do not report 36254 in conjunction with 36252)

(Placement of closure device at the vascular access site is not separately reported with 36251-36254)

(Do not report 36251, 36252, 36253, 36254 in conjunction with 37X47, 37X48 0338T, 0339T)

Transcatheter Procedures

Venous Mechanical Thrombectomy

37187 *Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance*

(Do not report 37187 in conjunction with 76000, 96375)

37188 *Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy*

(Do not report 37188 in conjunction with 76000, 96375)

Renal Nerve Denervation (Black bold heading)

Codes 37X47, 37X48 describe transcatheter renal sympathetic denervation. Code 37X47 is reported for bilateral denervation of first order main renal artery(ies) and any accessory renal artery(ies). Code 37X48 is reported for bilateral denervation of first order main renal artery(ies), any accessory renal artery(ies) and second order or higher renal artery branches. For a unilateral procedure, report 37X47, 37X48 with modifier 52.

Codes 37X47, 37X48 include arterial puncture, selective catheter placement in the renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation. Pressure gradient measurements, flush aortogram, and diagnostic renal angiography are not separately reported when performed.

●37X47 Transcatheter renal sympathetic denervation, percutaneous, including arterial puncture, selective catheter placement(s), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed, bilateral; first order main and any accessory renal arteries

●37X48 second order or higher renal artery branches

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(37X48 is used to report a bilateral procedure. For unilateral procedure, use modifier 52)

(Do not report 37X48 in conjunction with 37X47, 75625)

(Do not report 37X47, 37X48 in conjunction with 36251, 36252, 36253, 36254, 0935T)

(For transurethral renal pelvic sympathetic denervation, use 0935T)

Intravascular Ultrasound Services

+37252 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)*

+37253 *each additional noncoronary vessel (List separately in addition to code for primary procedure)*

(Use 37253 in conjunction with 37252)

(Use 37252, 37253 in conjunction with 33361, 33362, 33363, 33364,

33365, 33366, 33367, 33368, 33369, 33477, 33880, 33881, 33882, 33883, 33886, 34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708, 34709, 34710, 34711, 34712, 34718, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 36010, 36011, 36012, 36013, 36014, 36015, 36100, 36140, 36160, 36200, 36215, 36216, 36217, 36218, 36221, 36222, 36223, 36224, 36225, 36226, 36227, 36228, 36245, 36246, 36247, 36248, 36251, 36252, 36253, 36254, 36481, 36555-36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 36595, 36901, 36902, 36903, 36904, 36905, 36906, 36907, 36908, 36909, 37X47, 37X48, 37184, 37185, 37186, 37187, 37188, 37200, 37211, 37212, 37213, 37214, 37215, 37216, 37218, 37236, 37237, 37238, 37239, 37241, 37242, 37243, 37244, 37246, 37247, 37248, 37249, 37254-37299, 61623, 75600, 75605, 75625, 75630, 75635, 75705, 75710, 75716, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75774, 75805, 75807, 75810, 75820, 75822, 75825, 75827, 75831, 75833, 75860, 75870, 75872, 75885, 75887, 75889, 75891, 75893, 75894, 75898, 75901, 75902, 75970, 76000, 77001, 0075T, 0076T, 0234T, 0235T, 0236T, 0237T, 0238T, 0338T)

Category III Codes

~~0338T~~ ~~Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral~~

~~0339T~~ ~~bilateral~~

~~(Do not report 0338T, 0339T in conjunction with 36251, 36252, 36253, 36254)~~

~~(0338T, 0339T have been deleted)~~

~~(For percutaneous transcatheter renal sympathetic denervation, see 37X47, 37X48)~~

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(For quantitative pupillometry with interpretation and report, unilateral or bilateral, use 95919)

0935T Cystourethroscopy with renal pelvic sympathetic denervation, radiofrequency ablation, retrograde ureteral approach, including insertion of guide wire, selective placement of ureteral sheath(s) and multiple conformable electrodes, contrast injection(s), and fluoroscopy, bilateral

(Do not report 0935T in conjunction with 37X47, 37X48, 52000, 52005, 76000, ~~0338T, 0339T~~)

Typical Patient (37X47)

A 63-year-old male with a history of treatment resistant hypertension presents with high systolic blood pressure greater than 160 mmHg. The patient elects to proceed with the procedure. Renal nerve denervation is performed.

Typical Patient (37X48)

A 66-year-old female with a history of resistant hypertension presents with high systolic blood pressure of = 165 mmHg, despite the patient's adherence to a drug regimen involving 3-4 antihypertensive medications. During transcatheter RDN the patient requires treatment beyond the main renal arteries and accessories, and additional second order branches are treated.

Tab 20-Deep Venous Arterialization (DVA)

This action will be effective in the CPT 2028 code set.

Tab 20 was extracted from the Final Consent Agenda published 9-11-2026.

The Panel accepted with modifications on-site Option F of this request to: (1) add guidelines to the Endovascular Revascularization of Lower Extremities for Arterial Occlusive Disease subsection; (2) establish code 37X49 for reporting endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft; (3) add instructional and exclusionary parenthetical notes following 37X49 regarding appropriate reporting of the new codes; (4) revise exclusionary parenthetical notes following 37249, 37239, 76937 by replacing the deleted code with new code; (5) delete Category III code 0620T and all corresponding parenthetical notes; (6) add parenthetical notes to inform users of the deleted code and instructional parenthetical notes to direct users appropriate reporting of the new codes.

The Panel modified this request by: deleting the terms “with venous stent placement codes 37238, 37239 or venous angioplasty codes 37248, 37249 or codes for transluminal infra-geniculate”; (2) adding the term “transluminal”; and (2) replacing the term “segment” with “territory”.

Category I

Surgery

Cardiovascular System

Arteries and Veins

Endovascular Revascularization (Open or Percutaneous, Transcatheter)

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Endovascular Revascularization of Lower Extremities for Arterial Occlusive Disease

Codes 37254-37299 describe lower extremity endovascular revascularization services performed percutaneously and/or through an open surgical exposure for occlusive disease, including:

...

Mechanical thrombectomy and/or thrombolysis in the lower extremity vessels are sometimes necessary to aid in restoring flow to areas of occlusive disease, and are reported separately.

Deep venous arterialization (DVA) describes a percutaneous lower extremity revascularization procedure performed in patients with chronic limb-threatening ischemia (CLTI) when traditional options are not feasible. It involves creating a connection between the arteries and deep veins in the lower leg through arterial and venous catheterization, angioplasty, venous valvulotomy and endovascular stent placement.

Code 37X49 is used to report DVA in the tibial and peroneal vascular territory. It includes all ipsilateral selective arterial and venous catheterization, all diagnostic imaging for ipsilateral, lower extremity arteriography, imaging guidance, and all related radiological supervision and interpretation.

Transluminal arterial angioplasty, venous angioplasty, and/or stent placement is inherent to deep venous arterialization, when performed in the same tibial or peroneal territory.

Do not report tibial/peroneal and inframalleolar transluminal revascularization codes 37280-37299, venous stent placement codes 37238, 37239, or venous angioplasty codes 37248, 37249, when performed in the same DVA territory.

Arterial lower extremity revascularization within the iliac vascular territory (37254, 37255, 37256, 37257, 37258, 37259, 37260, 37261, 37262), or femoral and popliteal vascular territory (37263-37279) may be separately reported, when performed.

Inframalleolar Vascular Territory

- #37298 *Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel*
(For bilateral procedure, report 37298 with modifier 50)
- #+37299 *complex lesion, each additional vessel (List separately in addition to code for primary procedure)*
(Use 37299 in conjunction with 37298)
(For bilateral procedure, report 37299 twice. Do not report modifier 50 in conjunction with 37299)
- 37X49 *Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to*

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complete the intervention, all associated radiological supervision and interpretation, when performed

(Do not report 37X49 in conjunction with 37238, 37239, 37248, 37249)

(Do not report 37X49 in conjunction with ipsilateral arterial tibial or peroneal revascularization 37280-37299)

(For iliac, femoral and popliteal vascular territory lower extremity arterial revascularization, see [37254-37279])

Endovascular Revascularization, Transluminal Balloon Angioplasty (Other Than Central Nervous System, Coronary, Pulmonary, Lower Extremity for Occlusive Disease, and Dialysis Circuit When Approached Through Ipsilateral Dialysis Access)

#37248 *Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein*

#**+**37249 *each additional vein (List separately in addition to code for primary procedure)*

(Use 37249 in conjunction with 37248)

(Do not report 37248, 37249 in conjunction with 36836, 36837)

(Do not report 37248, 37249 in conjunction with 37238, 37239 when performed in the same vein during the same operative session)

(Do not report 37248, 37249 in conjunction with 0505T, within the femoral-popliteal segment)

(Do not report 37248, 37249 in conjunction with ~~0620T~~ 37X49 within the tibial-peroneal segment)

(For transluminal balloon angioplasty in aorta/visceral artery[ies] in conjunction with fenestrated endovascular repair, see 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848)

(For transluminal balloon angioplasty in a dialysis circuit performed through the circuit, see 36902, 36903, 36904, 36905, 36906, 36907, 36908)

(For transluminal balloon angioplasty to treat stenosis or occlusion in iliac, femoral, popliteal, tibial, peroneal, or inframalleolar artery[ies], see 37254, 37255, 37256, 37257, 37263, 37264, 37265, 37266, 37280, 37281, 37282, 37283, 37296, 37297, 37298, 37299)

(For transluminal balloon angioplasty in an intracranial artery, see 61630, 61635)

(For transluminal balloon angioplasty in a coronary artery, see 92920-92945)

(For transluminal balloon angioplasty in a pulmonary artery, see 92997, 92998)

Endovascular Revascularization, Transcatheter Intravascular Stent (Other Than Lower Extremity for Arterial Occlusive Disease, Cervical Carotid, Intracranial, Intracoronary Innominate and/or

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Intrathoracic Carotid, Extracranial Vertebral Artery, and Dialysis Circuit When Approached Through Ipsilateral Dialysis Access)

37238 *Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein*

+37239 *each additional vein (List separately in addition to code for primary procedure)*

(Use 37239 in conjunction with 37238)

(Do not report 37238, 37239 in conjunction with 36836, 36837)

(Do not report 37238, 37239 in conjunction with 0505T, within the femoral-popliteal segment)

(Do not report 37238, 37239 in conjunction with ~~0620T~~ 37X49 within the tibial-peroneal segment)

(For placement of a stent[s] within the peripheral segment of the dialysis circuit, see 36903, 36906)

(For transcatheter placement of an intravascular stent[s] within central dialysis segment when performed through the dialysis circuit, use 36908)

Radiology Diagnostic Ultrasound Ultrasonic Guidance Procedures

+76937 *Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)*

(Do not report 76937 in conjunction with 33274, 33275, 36568, 36569, 36572, 36573, 36584, 36836, 36837, 37191, 37192, 37193, 37760, 37761, 76942, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0823T, 0824T, 0825T)

(Do not report 76937 in conjunction with 0505T, ~~0620T~~ 37X49 for ultrasound guidance for vascular access)

(If extremity venous non-invasive vascular diagnostic study is performed separate from venous access guidance, see 93970, 93971)

Category III Codes

~~#0620T — Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed~~

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~~(0620T includes all ipsilateral selective arterial and venous catheterization, all diagnostic imaging for ipsilateral, lower extremity arteriography, and all related radiological supervision and interpretation)~~

~~(Do not report 0620T in conjunction with 37238, 37239, 37248, 37249, 37280-37295, within the tibial-peroneal segment)~~

(0620T has been deleted)

(For endovascular tibial or peroneal vein deep venous arterialization, use 37X49)

Typical Patient (37X49)

A 66-year-old female presents with non-healing ulcers on her right foot and toes. She has a known history of chronic total occlusion of the posterior tibial artery with prior failed revascularization attempts. Prior diagnostic angiography demonstrated poor arterial run-off. The patient ~~was determined to be a candidate for~~ undergoes endovascular tibial vein arterialization.

Tab 21-Central Venous Catheter Insertion Services

This action will be effective in the CPT 2028 code set.

Tab 21 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted Option B of this request to: (1) delete code 36557; (2) add a deletion parenthetical note cross referencing to codes 36XX0, 36X10, 36X11, 36X12, 36X13, 36X14; (3) establish codes 36XX0, 36X10-36X15 to report insertion of tunneled centrally inserted central venous access catheter without subcutaneous port, based on age; (4) add instructional parenthetical notes that define postnatal age and postconception age and provide instruction on the appropriate reporting of codes 36X10-36X14; (5) revise code 36558 to describe insertion of tunneled centrally inserted central venous *access* catheter, without a subcutaneous port in a patient age 5 years or older; (6) establish add-on codes 36X16 and 36X17 to report insertion of tunneled centrally inserted central venous access device with a subcutaneous port, when inserted at the time of another procedure, in patients age younger than 5 years (36X16) and 5 years or older (36X17); (7) delete code 36563; (8) add a deletion parenthetical note cross referencing to codes 36XX0, 36X10, 36X11, 36X12, 36X13, 36X14; (9) revise codes 36565 and 36566 to clarify they describe insertion of two separately tunneled centrally inserted central venous accesses; (10) add an instructional parenthetical note stating that codes 36565 and 36566 are reported for insertion of two-catheter systems and not for dual-lumen single catheters; (11) delete cross-reference parenthetical note following code 36570 that directs to code 36560; (12) revise cross-reference parenthetical note following code 36571 by removing reference to age and to direct to codes 36560, 36X16, and 36X17; (13) add three parenthetical notes following code 36X10 and 36X12 regarding postconception age and postnatal age as they relate to the codes in this section; (14) delete cross-reference parenthetical note following 36558; (15) add cross-reference parenthetical note following code 36X17 directing users to codes 36570 and 36571; (16) revise the Insertion of Tunneled Central Venous Catheter illustration by removing code 36557 and adding the word “access” to the title; and (17) revise typical patient descriptions for codes 36558, 36560, 36561, 36565, and 56566.

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Category I
Cardiovascular System
Arteries and Veins
Vascular Injection Procedures
Central Venous Access Procedures
Insertion of Central Venous Access Device

~~36557~~ Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age

(36557 has been deleted. To report, see 36XX0, 36X10, 36X11, 36X12, 36X13, 36X14)

●36XX0 Insertion of tunneled centrally inserted central venous access catheter, without subcutaneous port; preterm infant (younger than 37 weeks gestation at birth), birth to 50 weeks postconception age

✚●36X10 preterm infant (younger than 37 weeks gestation at birth), birth to 50 weeks postconception age, when inserted at time of other procedure (List separately in addition to code for primary procedure)

(Do not report modifier 63 in conjunction with 36XX0, 36X10)

(Postnatal age equals time since birth. Postconception age equals gestational age at birth plus postnatal age of infant, in weeks, at the time of the tunneled centrally inserted central venous access catheter. For insertion of a tunneled centrally inserted central venous access catheter in preterm infants [younger than 37 weeks gestation at birth] who are older than 50 weeks postconception age and younger than age 6 months postnatal age at the time of surgery, see 36X11, 36X12. For insertion of a tunneled centrally inserted central venous access catheter in infants age 6 months to younger than 5 years postnatal age, see 36X13, 36X14)

(Postnatal age equals time since birth. Postconception age equals gestational age at birth plus postnatal age of infant, in weeks, at the time of the tunneled centrally inserted central venous access catheter)

(For insertion of a tunneled centrally inserted central venous access catheter in full term infant younger than age 6 months postnatal age or preterm infants [younger than 37 weeks gestation at birth] who are older than 50 weeks postconception age and younger than age 6 months postnatal age at the time of surgery, see 36X11, 36X12)

(For insertion of a tunneled centrally inserted central venous access catheter in infants age 6 months to younger than 5 years postnatal age, see 36X13, 36X14)

●36X11 full term infant younger than age 6 months postnatal age, or preterm infant (younger than 37 weeks gestation at birth) older than 50 weeks postconception age and younger than age 6 months postnatal age

✚●36X12 full term infant younger than age 6 months postnatal age, or preterm infant (younger than 37 weeks gestation at birth) older than 50 weeks postconception

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age and younger than age 6 months postnatal age, when inserted at time of other procedure (List separately in addition to code for primary procedure)

(Postnatal age equals time since birth. Postconception age equals gestational age at birth plus postnatal age of infant, in weeks, at the time of the tunneled centrally inserted central venous access catheter. For insertion of a tunneled centrally inserted central venous access catheter in preterm infants [younger than 37 weeks gestation at birth] who are younger than or up to 50 weeks postconception age but younger than 6 months postnatal age at time of procedure, see 36XX0, 36X10. For insertion of a tunneled centrally inserted central venous access catheter in infants age 6 months to younger than 5 years postnatal age, see 36X13, 36X14)

(Postnatal age equals time since birth. Postconception age equals gestational age at birth plus postnatal age of infant, in weeks, at the time of the tunneled centrally inserted central venous access catheter)

(For insertion of a tunneled centrally inserted central venous access catheter in preterm infants [younger than 37 weeks gestation at birth] are younger than or up to 50 weeks postconception age but younger than 6 months postnatal age at time of procedure, see 36XX0, 36X10)

(For insertion of a tunneled centrally inserted central venous access catheter in infants age 6 months to younger than 5 years postnatal age, see 36X13, 36X14)

●36X13

age 6 months to younger than 5 years

✚●36X14

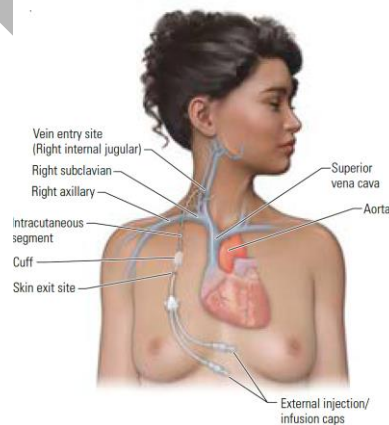
age 6 months to younger than 5 years, when inserted at time of other procedure (List separately in addition to code for primary procedure)

▲36558

age 5 years or older

(For peripherally inserted central venous device catheter with port, 5 years or older, use 36571)

Insertion of Tunneled Central Venous Catheter
36557-36558



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✚●36X15 age 5 years or older, when inserted at time of other procedure (List separately in addition to code for primary procedure)

36560 *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age*
(For peripherally inserted central venous access device with subcutaneous port, younger than 5 years of age, use 36570)

✚●36X16 younger than 5 years of age, when inserted at time of other procedure (List separately in addition to code for primary procedure)

36561 *age 5 years or older*
~~(For peripherally inserted central venous device catheter with subcutaneous port, 5 years or older, use 36571)~~

✚●36X17 age 5 years or older, when inserted at time of other procedure (List separately in addition to code for primary procedure)

(For peripherally inserted central venous access device, with subcutaneous port, see 36570, 36571)

~~36563 Insertion of tunneled centrally inserted central venous access device with subcutaneous pump~~
~~(36563 has been deleted. To report, see 36XX0, 36X10, 36X11, 36X12, 36X13, 36X14)~~

▲36565 Insertion of 2 separately tunneled centrally inserted central venous accesses; device catheters, requiring 2 catheters via 2 separate venous access sites; without subcutaneous ports or pump (eg, Tesio type catheter)

▲36566 ~~Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; device(s) with subcutaneous port(s)~~
(36565, 36566 are reported for insertion of 2-catheter systems and are not reported for dual-lumen single catheters)

36570 *Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age*
~~(For insertion of tunneled centrally inserted central venous access device with subcutaneous port, younger than 5 years of age, use 36560)~~

36571 *age 5 years or older*
~~(For insertion of tunneled centrally inserted central venous access device with subcutaneous port, age 5 years or older, use 36561)~~ see 36560, 36X16, 36X17)

Typical Patient (36XX0)

A 1000-gram former 27 week, now 29 week-postconception, female with sepsis requires long term central venous access (eg, total parenteral nutrition [TPN], blood draws).

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Typical Patient (36X10)

At the time of a separately reported procedure (eg, laparotomy), a 1000-gram former 27 week, now 29 week- postconception female with necrotizing enterocolitis requires long term central venous access (eg, total parenteral nutrition [TPN], blood draws). [Note: This is an add-on code. Only consider the additional work related to insertion of a tunneled centrally inserted central venous access catheter without subcutaneous port.]

Typical Patient (36X11)

A 1-month-old, full term female with feeding intolerance requires long term venous central access (eg, total parenteral nutrition [TPN]).

Typical Patient (36X12)

At the time of a separately reported procedure (eg, laparotomy), a 2-day-old full term female with malrotation with volvulus requires long term central venous access (eg, total parenteral nutrition [TPN], blood draws). [Note: This is an add-on code. Only consider the additional work related to insertion of a tunneled centrally inserted central venous access catheter without subcutaneous port.]

Typical Patient (36X13)

A 2-year-old female with acute myeloid leukemia (AML) requires long term central venous access (eg, chemotherapy).

Typical Patient (36X14)

Prior to a separately reported procedure (eg, laparotomy), a 2-year-old female with neuroblastoma requires long term central venous access (eg, chemotherapy, blood draws). [Note: This is an add-on code. Only consider the additional work related to insertion of a tunneled centrally inserted central venous access catheter without subcutaneous port.]

REVISED Typical Patient (36558)

~~A 5562-year-old male with end stage renal disease requires long term central venous access (eg, hemodialysis) needs long term CV access. A tunneled centrally inserted CV dialysis catheter is placed.~~

Typical Patient (36X15)

At the time of a separately reported procedure (eg, dialysis access thrombectomy), a 50-year-old diabetic male with chronic kidney disease requires long term central venous access. [Note: This is an add-on code. Only consider the additional work related to insertion of tunneled centrally inserted central venous access catheter without subcutaneous port.]

REVISED Typical Patient (36560)

~~A 3-year-old male female with acute lymphocytic leukemia (ALL) requires long term central venous access with port (eg, chemotherapy, blood draws). is admitted and requires long term central venous catheter. A tunneled centrally inserted central venous catheter with a subcutaneous port is inserted.~~

Typical Patient (36X16)

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At the time of a separately reported procedure (eg, laparotomy or thoracotomy for tumor resection), a 3-year-old female requires long term central venous access with port (eg, chemotherapy, blood draws). [Note: This is an add-on code. Only consider the additional work related to insertion of a tunneled centrally inserted central venous catheter with subcutaneous port.]

REVISED Typical Patient (36561)

A ~~6245~~-year-old female with lung cancer requires long term central venous access with port (eg, chemotherapy, blood draws). ~~requires long term CV access. A tunneled centrally inserted CV catheter with subcutaneous port is inserted.~~

Typical Patient (36X17)

At the time of a separately reported procedure (eg, staging laparoscopy for abdominal malignancy), a 67-year-old male requires long term central venous access with port (eg, chemotherapy, blood draws). [Note: This is an add-on code. Only consider the additional work related to insertion of a tunneled centrally inserted central venous catheter with subcutaneous port.]

REVISED Typical Patient (36565)

A 55-year-old male requires separate long term central venous accesses for hemodialysis and long-term antibiotics. ~~with end stage renal disease is referred for a tunneled CV access device. Decision is made to place a two-catheter system via separate venous access sites.~~

Revised: Typical Patient (36566)

A ~~4664~~-year-old female with myasthenia gravis with complex venous access history requires separate long term central venous accesses with ports for plasmapheresis and intravenous infusions with frequent blood draws. ~~chronic renal failure patient requires long term catheter access for dialysis. She is referred for placement of a multicatheter multiport central venous dialysis system for anticipated long term use.~~

Tab 22-Tibial Intravascular Lithotripsy (IVL)-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 23-Venous Ablation Guideline Revision

The Panel rejected this request to revise the introductory guidelines for Venous Ablation to specify that abrasion is not the only method of mechanical disruption that may be used when reporting codes [36473](#), [36474](#).

As rationale for rejection of this request, the Panel noted that the following CPT Criteria have not been met:

General CPT Code Criteria:

B2. The descriptor structure, guidelines and instructions are consistent with current Editorial Panel standards for maintenance of the code set.

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Tab 24-Stab Phlebectomy-Varicose Veins

This action will be effective in the CPT 2028 code set.

Tab 24 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted Option B of this request to: (1) add guidelines in the Ligation subsection; (2) establish code 37X50 reporting stab phlebectomy for varicose veins; (3) revise code 37765 from a parent code to a child code; (4) delete two parenthetical notes following 37765; and (5) add a parenthetical note following 37766.

Category I Surgery Cardiovascular System Arteries and Veins Ligation

When performing bilateral stab phlebectomy for varicose veins, report 37X50, 37765, 37766 with modifier 50 if the same code applies to both extremities. For example, if 10-20 incisions are performed on each leg, report 37765 and modifier 50.

If a different number of stab incisions is performed on each leg during the same session, report each side separately using the appropriate codes and modifier 59. For example, if more than 20 incisions are performed on the right leg and 10-20 incisions on the left leg, report 37766 for the right leg and 37765 with modifier 59 for the left leg.

(For phleborrhaphy and arteriorrhaphy, see 35201-35286)

37565 *Ligation, internal jugular vein*

...

37761 *Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg*

(For bilateral procedure, report 37761 with modifier 50)

(Do not report 37760, 37761 in conjunction with 76937, 76942, 76998, 93971)

●37X50 *Stab phlebectomy of varicose veins, 1 extremity; 1-9 incisions*

▲37765 ~~*Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions*~~

~~*(For less than 10 incisions, use 37799)*~~

~~*(For more than 20 incisions, use 37766)*~~

37766 *more than 20 incisions*

(For transilluminated powered phlebectomy [TIPP], use 37799)

Typical Patient (37X50)

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A 40-year-old female presents with a history of bulging veins in her lower left leg that worsen throughout the day, affecting her ability to perform activities. She reports that compression therapy stockings provide minimal relief for extremity pain, swelling, achiness, and heaviness. The patient undergoes stab phlebectomy.

Typical Patient (37765)

A 40-year-old female presents with a history of bulging veins in her lower left leg that worsen throughout the day, affecting her ability to perform activities. She reports that compression therapy stockings provide minimal relief for extremity pain, swelling, achiness, and heaviness. The patient undergoes stab phlebectomy.

Typical Patient (37766)

A 40-year-old female presents with a history of bulging veins in her lower left leg that worsen throughout the day, affecting her ability to perform activities. She reports that compression therapy stockings provide minimal relief for extremity pain, swelling, achiness, and heaviness. The patient undergoes stab phlebectomy.

Tab 25-Appendectomy

The Panel rejected this request to restructure the open and laparoscopic appendectomy codes based on age and complexity (ie, complicated vs. uncomplicated) by: (1) deleting appendectomy code 44955; (2) establishing four new appendectomy codes (44XX4-44XX7) in the Appendix/Excision subsection and five codes (44XX8-44X12) in the Appendix/Laparoscopy subsection; and (3) revise codes 44950, 44960, and 44970.

As rationale for rejection of this request, the Panel noted that the following CPT Criterion has not been met:

General CPT Criterion:

B3: The proposed descriptor for the procedure or service is neither a fragmentation of an existing procedure or service nor currently reportable as a complete service by 1 or more existing codes (with the exclusion of unlisted codes).

Tab 26-Machine Perfusion Services-Liver Allograft-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 27-Histotripsy-Liver Tumor

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The Panel rejected this request to delete Category III code 0686T and establish Category I codes 47XX0, 47XX6, 47XX7 for reporting histotripsy of the liver, one or more tumors.

As rationale for rejection of this request, the Panel noted that the following CPT Criteria have not been met:

Specific Criteria For Category I:

C5. The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code-change application.

Tab 28-Transperineal Laser Ablation (TPLA)-BPH

The Panel rejected this request to: (1) delete Category III codes 0714T, 0867T; and (2) establish 55X02, 55X03 to report transperineal laser ablation of benign hyperplasia of the prostate.

As rationale for rejection of this request, the Panel noted that the following CPT Criteria have not been met:

Specific Criterion For Category I Codes:

C2: The procedure or service is performed by many physicians or other qualified health care professionals across the United States;

C3: 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).

Tab 29-Water Vapor Thermotherapy Ablation-Prostate Tissue

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tab 29 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted Option B of this request to: (1) revise Category III code 0582T to include the term “initial lesion” for transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy”; (2) establish X726T to report each additional lesion of ablation; and (3) add three parenthetical notes following code X726T regarding appropriate reporting for this code.

Category III Codes

▲0582T Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance; initial lesion

Sunset: January 2030-2032

(Do not report 0582T in conjunction with 52000, 72195, 72196, 72197, 76376, 76377, 76872, 76940, 76942, 77021, 77022)

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(For transurethral destruction of prostate tissue by radiofrequency-generated water vapor thermotherapy for benign prostatic hypertrophy [BPH], use 53854)

#+● X726T each additional lesion (List separately in addition to code for primary procedure)

Sunset: January 2032

(Use X726T in conjunction with 0582T)

(For Report X726T, for malignant tumor areas are defined as separate foci for additional lesions only when if at least 2 mm of benign tissue is present between 2 cancerous areas)

(For Use X726T for each additional lesion that requires the physician or other qualified health care professional to perform all procedural steps necessary to achieve destruction of each specific tumor, use X726T)

REVISED Typical Patient (0582T)

A 72-year-old male with an elevated PSA after prior negative prostate biopsy undergoes MRI, which reveals two suspicious lesions, one in the right apical peripheral zone and one in the left anterior transitional zone of his prostate. MRI/ultrasound (US) fusion biopsy of each lesion confirms Gleason 76 adenocarcinoma. The patient elects focal ablation of the lesions by high energy water vapor thermotherapy with intraoperative imaging and needle guidance.

A 60-year-old male is diagnosed with localized prostate cancer. The MRI shows a right posterior mid prostate, PIRADS 4 lesion confirmed by biopsy as Gleason Grade Group 2 disease (3+4). Two of the sector cores on the contralateral side at the lateral base show Gleason Grade Group 2 disease (3+4). The patient does not want active surveillance and desires simultaneous focal treatment of both lesions using high-energy water vapor thermotherapy.

REVISED Description of Procedure (0582T)

The patient receives general anesthesia and is placed in the lithotomy position. Mount a transrectal US probe onto a stepper unit and position in the rectum to visualize the prostate. Complete a thorough US examination of the prostate (including volumetric and treatment measurements) as well as anterior rectal wall and periprostatic space. Under real time US guidance, advance an 18-g needle just anterior to the rectum into the periprostatic space. Inject 1 to 2 cc of normal saline to assist identifying the proper location of the needle and then connect to a saline pump to be used later during the water vapor treatment cycle. Using a standard vapor cartridge, pass the disposable cystoscopic device into the prostatic urethra and localize by real time US tracking. Using the MRI guidance system and uploaded MRI images, complete the MRI/US fusion process and identify the left anterior transitional zone target. Guide the vapor needle to the center of the target utilizing US and the needle tracking guidance system. As the needle is deployed, monitor the bio-capacitance safety system to avoid breach of the prostatic capsule. When the vapor needle location is confirmed, initiate the periprostatic saline infusion followed by vapor delivery into the target at the standard setting of 400 calories per vapor treatment. After each treatment, the needle may be slightly advanced or retracted and vapor treatment repeated if additional ablation is needed, until the target lesion is completely ablated. After confirming complete ablation of the left transitional zone lesion, retract the needle and replace into the right apical peripheral zone lesion. Repeat

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~~the water vapor treatment cycle(s) until that lesion is completely ablated. Retract the needle and remove the device. Place a Foley catheter and send the patient to the recovery room.~~

Preoperative antibiotics are given, anesthesia administered, and the patient placed in the low lithotomy position, prepped, and draped. The biplanar transrectal ultrasound (TRUS) probe is placed in the cradle of the stabilizer system and positioned in the rectum. The prostate, seminal vesicles, and periprostatic tissues are examined. Using real-time ultrasound guidance, an 18-gauge centesis catheter is properly positioned between the rectum and prostate taking care not to inadvertently puncture the rectum or prostatic apex. Proper positioning is confirmed by injecting 1-2cc of saline while visualizing under ultrasound. The catheter is connected to the generator saline pump via tubing to automatically deliver periprostatic saline during vapor delivery. The delivery device needle is calibrated, and the system is activated by delivering a pre-treatment vapor cycle outside the body and away from the patient. The disposable cystoscopic device is passed into the bladder under endoscopic control and attached to the stabilizer arm. The electromagnetic field generator for the navigational system (NGS) is positioned, and the screen avatar overlays properly calibrated. The preoperative MRI and lesion location information is transferred to the real-time ultrasound image for targeting the treatment plane using the NGS. The TRUS image is aligned to the target area and, using the avatars, the treatment needle is rotated and aligned with the target and locked in place with the stabilizer system. The physician determines the pre-deployment length and uses the remote to deploy the needle to the target while monitoring the needle position under ultrasound guided by the NGS. A tissue bio-capacitance measuring system on the needle tip is used to optimize its position within the prostate. As the vapor treatment(s) is delivered, the physician monitors endoscopically and under real-time ultrasound for treatment effectiveness and retracts the needle when complete. If necessary, the remainder of the visualized target plane is treated by redeploying the needle delivering additional vapor cycles. The overall treatment is evaluated by the physician using ultrasound to re-examine the treatment area and entire prostate. If no additional distinct malignant lesions are identified, and the physician determines adequate treatment has been performed, the procedure is complete and a Foley catheter inserted.

Typical Patient (X726T)

A 60-year-old male is diagnosed with localized prostate cancer. The MRI shows a right posterior mid prostate, PIRADS-4 lesion confirmed by biopsy as Gleason Grade Group 2 disease (3+4). Two of the sector cores on the contralateral side at the lateral base show Gleason Grade Group 2 disease (3+4). The patient does not want active surveillance and desires simultaneous focal treatment of both lesions using high-energy water vapor thermotherapy. [Note: This is an add-on code. Only consider the additional work for each additional lesion that requires the physician or other qualified healthcare professional to perform all procedural steps to ensure destruction of each specific tumor.]

Description of Procedure (X726T)

~~If additional~~ Following an initial, distinct, imaged, confirmed malignant lesions are identified (ie, separate foci of at least 2mm of benign tissue is present between two cancerous areas), the physician repeats the procedural steps of 0582T separately for each additional lesion. To begin, the physician inserts a catheter to drain the bladder, removes the catheter, and clears residual periprostatic saline by probe maneuvering. The physician evaluates the image quality and re-optimizes it for the new target. If the new treatment area is located on the contralateral side posteriorly, the physician places a second

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transperineal centesis catheter, determines the proper location of the centesis catheter, and aligns the ultrasound to that location. The physician then attaches the needle guide to the ultrasound probe. The needle/catheter is inserted into the periprostatic space under ultrasound guidance and the guide removed. The needle/catheter is advanced to its target location, the needle removed and the indwelling centesis catheter connected to the thermotherapy system. Next, the physician re-registers the apical registration line on the device console, transfers the imaging and biopsy targeting data for the new lesion into the targeting system, repositions the transrectal ultrasound to align with the new target area; and maneuvers the delivery device to align with the new lesion using the on-screen guidance system. The physician determines the needle deploy distance and then deploys the needle. The physician interprets the ultrasound image, needle guidance system, and bio-capacitance data to guide the needle to the target and treats the additional area. Additional vapor cycles are delivered following the same overlapping ~1 cm spacing pattern guided by physician interpretation of the ultrasound findings, including video replay if necessary. When the physician determines adequate additional treatment has been performed, the procedure is complete and a Foley catheter inserted.

Tab 30-Cranial Neurostimulator Subsection Revisions-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 31-Cranial Nerve Neurostim Svs-Hypoglossal Nerve

This action will be effective in the CPT 2028 code set.

The Panel accepted Option C of this request to: (1) add new cross reference parentheticals under code 61886 and an exclusionary parenthetical under 61888; (2) add new cross reference parentheticals under codes 64568, 64569, 64570 to direct to how to code for the single-lead hypoglossal nerve; (3) add new cross reference parentheticals under codes 64582, 64583, 64584 to direct to how to code for the single-lead hypoglossal nerve neurostimulator; (4) add three new codes (64XXX, 64XX0, 64XX1) and add new exclusionary and reference parentheticals under the three new codes; (5) add the new codes to appropriate parentheticals under the Neurostimulators, Analysis-Programming section; and (6) add the appropriate new codes to the exclusionary parenthetical for code 95970.

Category I Surgery Nervous System Skull, Meninges, and Brain Neurostimulators (Intracranial)

61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array*

61886 *with connection to 2 or more electrode arrays*

(For percutaneous placement of cranial nerve ([eg, vagus, trigeminal]) neurostimulator electrode([s]), use 64553])

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(For revision or removal of cranial nerve (eg, vagus, trigeminal) neurostimulator electrode array, use 64569)]

(For open implantation of a single-lead hypoglossal nerve neurostimulator electrode array and pulse generator, use 64XXX)

(For open implantation of a hypoglossal nerve neurostimulator electrode array, pulse generator, with a distal respiratory sensor electrode or electrode array, dual-lead, use 64582)

61888

Revision or removal of cranial neurostimulator pulse generator or receiver

(Do not report 61888 in conjunction with 61885 or 61886 for the same pulse generator)

(Do not report 61888 in conjunction with 64570, 64584, 64XX1)

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System Neurostimulators (Peripheral Nerve)

▲64568

Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator *(excluding hypoglossal nerve)*

(Do not report 64568 in conjunction with 61885, 61886, 64570)

(For open implantation of hypoglossal nerve neurostimulator electrode array, pulse generator, with a ~~and~~ distal respiratory sensor electrode or electrode array, dual-lead, use 64582)

(For open implantation of a single-lead hypoglossal nerve neurostimulator electrode array and pulse generator, use 64XXX)

(For open implantation of vagus nerve integrated neurostimulation system, see 0908T, 0909T)

(For open implantation of bilateral supraorbital-occipital neurostimulator, use 1057T)

▲64569

Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator *(excluding hypoglossal nerve)*

(Do not report 64569 in conjunction with 64570 or 61888)

(For replacement of pulse generator, use 61885)

(For revision or replacement of a hypoglossal nerve neurostimulator electrode array with a distal respiratory sensor electrode or electrode array, dual-lead, use 64583)

(For revision or replacement of a single-lead hypoglossal nerve neurostimulator electrode array, use 64XX0)

(For revision or replacement of bilateral supraorbital-occipital neurostimulator, use 1058T)

▲64570

Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator *(excluding hypoglossal nerve)*

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(Do not report 64570 in conjunction with 61888)

(For removal of a hypoglossal nerve neurostimulator electrode array, and pulse generator, with a distal respiratory sensor electrode or electrode array, dual-lead, use 64584)

(For removal of a single-lead hypoglossal nerve stimulator electrode array and pulse generator, use 64XX1)

(For removal of vagus nerve integrated neurostimulation system, use 0910T)

(For removal of bilateral supraorbital-occipital neurostimulator, use 1059T)

- ▲64582 Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array (dual-lead)

(For open implantation of a single-lead hypoglossal nerve neurostimulator electrode array and pulse generator, use 64XXX)

- ▲64583 Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator (dual-lead)

(Do not report 64583 in conjunction with 64582, 64584)

(For replacement of pulse generator, use 61886)

(For revision or replacement of either the hypoglossal nerve stimulator electrode array or distal respiratory sensor, dual-lead, use modifier 52)

(For revision or replacement of a single-lead hypoglossal nerve stimulator electrode array, use 64XX0)

- ▲64584 Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array (dual-lead)

(Do not report 64584 in conjunction with 61888, 64582, 64583)

(For removal of one or two components of the hypoglossal nerve stimulator electrode array, pulse generator, or distal respiratory sensor, dual-lead, use modifier 52)

(For removal of a single-lead hypoglossal nerve stimulator electrode array and pulse generator, use 64XX1)

- 64XXX Open implantation of a single-lead hypoglossal nerve neurostimulator electrode array and pulse generator

(Do not report 64XXX in conjunction with 61885, 64568, 64582)

(For open implantation of a hypoglossal nerve neurostimulator electrode array, pulse generator, with a distal respiratory sensor electrode or electrode array, dual-lead, use 64582)

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- 64XX0 Revision or replacement of single-lead hypoglossal nerve neurostimulator electrode array, including connection to existing pulse generator
(Do not report 64XX0 in conjunction with 64569, 64583)
(For replacement of pulse generator, use 61885)
(For revision or replacement of a hypoglossal nerve neurostimulator electrode array with a distal respiratory sensor electrode or electrode array, dual-lead, use 64583)
- 64XX1 Removal of single-lead hypoglossal nerve neurostimulator electrode array and pulse generator
(Do not report 64XX1 in conjunction with 64570, 64584)
(For removal of a hypoglossal nerve neurostimulator electrode array, pulse generator, with a distal respiratory sensor electrode or electrode array, dual-lead, use 64584)
(For removal of pulse generator only, use 61888)

Medicine

Neurostimulators, Analysis- Programming

Electronic analysis of an implanted neurostimulator pulse generator/transmitter involves documenting settings...

Code 95970 describes electronic analysis of the implanted brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve neurostimulator pulse generator/transmitter without programming. Electronic analysis is inherent to implantation codes 43647, 43648, 43881, 43882, 61850, 61860, 61863, 61864, 61867, 61868, 61880, 61885, 61886, 61888, 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688, 64553, 64555, 64561, 64566, 64568, 64569, 64570, 64575, 64580, 64581, 64585, 64590, 64595, 64XXX, and is not separately reportable at the same operative session.

Test stimulations are typically performed during an implantation procedure (43647, 43648, 43881, 43882, 61850, 61860, 61863, 61864, 61867, 61868, 61880, 61885, 61886, 61888, 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688, 64553, 64555, 64561, 64566, 64568, 64569, 64570, 64575, 64580, 64581, 64582, 64583, 64584, 64585, 64590, 64595, 64XXX) to confirm correct target site placement of the electrode array(s) and/or to confirm the functional status of the system. Test stimulation is not considered electronic analysis or programming of the neurostimulator system (test stimulation is included in the service described by the implantation code) and should not be reported with 95970, 95971, 95972, 95980, 95981, 95982, 95983, 95984. Electronic analysis of a device (95970) is not reported separately at the time of implantation.

(For insertion of neurostimulator pulse generator, see 61885, 61886, 63685, 64568, 64582, 64590, 64XXX)

(For revision or removal of neurostimulator pulse generator or receiver, see 61888, 63688, 64569, 64570, 64583, 64584, 64595, 64XX0)

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(For implantation of neurostimulator electrodes, see 43647, 43881, 61850-61868, 63650, 63655, 64553-64581. For revision or removal of neurostimulator electrodes, see 43648, 43882, 61880, 63661, 63662, 63663, 63664, 64569, 64569, 64570, 64583, 64584, 64585)

(For analysis and programming of implanted integrated neurostimulation system, posterior tibial nerve, see 0589T, 0590T)

95970 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming*

(Do not report 95970 in conjunction with 43647, 43648, 43881, 43882, 61850, 61860, 61863, 61864, 61867, 61868, 61880, 61885, 61886, 61888, 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688, 64553, 64555, 64561, 64X21, 64X22, 64X23, 64X24, 64566, 64568, 64569, 64570, 64575, 64580, 64581, 64582, 64583, 64584, 64585, 64590, 64595, 64XXX, 64XX0, ~~0988T~~, ~~0989T~~ during the same operative session)

(Do not report 95970 in conjunction with 95971, 95972, 95976, 95977, 95983, 95984)

Typical Patient (64XXX)

A 59-year-old male with moderate obstructive sleep apnea is referred for hypoglossal nerve stimulation therapy after being intolerant to continuous positive airway pressure (CPAP) therapy.

Typical Patient (64XX0)

A 60-year-old male with sleep apnea has a single-lead hypoglossal nerve stimulator which has developed a malfunction of the lead requiring replacement for ongoing therapy.

Typical Patient (64XX1)

A 58-year-old male with sleep apnea has become intolerant to an implanted single-lead hypoglossal nerve stimulator-system requiring removal.

Tab 32-Cryoneurolysis-Peripheral Nerve-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 33-Open Posterior Tibial Neurostimulator Services

This action will be effective in the CPT 2028 code set.

Tabs 33 and 34 were voted as a single Panel action.

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The Panel accepted on-site Option C of this request to: (1) revise the Guidelines in the Neurostimulators (Peripheral Nerve) subsection to describe the open placement of subcutaneous or subfascial integrated neurostimulation systems; (2) add two instructional parenthetical notes following 64585 reporting revision or removal of integrated neurostimulation system; (3) add two instructional parenthetical notes following 64590 reporting open implantation or replacement of integrated neurostimulator system; (4) add two instructional parenthetical notes reporting open implantation or replacement of integrated neurostimulator system, following 64597; (5) delete an instructional parenthetical note following 64597; (6) revise the instructional parenthetical note following 64598; (7) add codes 64X21, 64X22 reporting open implantation or replacement of integrated neurostimulation system and add corresponding parenthetical notes; (8) establish codes 64X23, 64X24 reporting open revision or removal of integrated neurostimulation system and corresponding parenthetical notes; (9) revise the parenthetical note following code 95970; (10) revise the parenthetical note following 0587T and 0588T; (11) delete Category III codes 0816T, 0817T, 0988T, 0818T, 0819T and 0989T and all corresponding parenthetical notes reporting open insertion, replacement, revision and removal of integrated neurostimulation system; and (12) add parenthetical notes to direct users of the deleted codes and to provide instructions on the appropriate reporting of the new codes.

Category I
Surgery
Nervous System
Extracranial Nerves,
Peripheral Nerves, and Autonomic Nervous System
Neurostimulators (Peripheral Nerve)

For electronic analysis with programming, when performed, of peripheral nerve neurostimulator pulse generator or transmitters, see codes 95970, 95971, 95972. An electrode array is a catheter or other device with more than one contact. The function of each contact may be capable of being adjusted during programming services. Test stimulation to confirm correct target site placement of the electrode array(s) and/or to confirm the functional status of the system is inherent to placement, and is not separately reported as electronic analysis or programming of the neurostimulator pulse generator or receiver system. Electronic analysis (95970) at the time of implantation is not separately reported.

A neurostimulator system includes an implanted pulse generator or implanted receiver with an external transmitter; a collection of contacts, electrodes (electrode array), an extension if applicable, an external controller; and an external charger, if applicable. The electrode array provides the actual electrical stimulation. The pulse generator or receiver may be integrated with the electrode array (single-component implant) or have a detachable connection to the electrode array (two or more component implant).

Codes 64553, 64555, and 64561 may be used to report both temporary and permanent placement of percutaneous electrode arrays.

Codes 64590, 64596 describe two different approaches to placing a neurostimulator pulse generator or receiver. Code 64590 is used in conjunction with 64555, 64561 for permanent placement. Codes 64555, 64561 are used to report electrode array placement for a trial and for the permanent placement of the electrode array. Code 64590 is used to report the insertion of a neurostimulator pulse generator or receiver

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that requires creation of a pocket and connection between the electrode array and the neurostimulator pulse generator or receiver. Code 64596 is used to report the permanent percutaneous placement of an integrated system, which includes ~~including~~ the electrode array and receiver.

Codes 64X21, 64X22 describe the open placement of subcutaneous or subfascial integrated neurostimulation systems. These integrated neurostimulation systems may consist of a unit with a built-in battery and electrode (eg, leadless), or a unit with an electrode and built-in receiver which uses an external generator to power and includes all components for providing neurostimulation treatment (eg, patient programmers, external batteries, or transmitters). Report revisions, or removal without replacement, of the system using 64X23, 64X24. Do not report 64X23, 64X24 during the same procedure as a replacement, as this is not separately reported.

- 64585 *Revision or removal of peripheral neurostimulator electrode array*
(For revision or removal of integrated neurostimulator system, subcutaneous posterior tibial nerve, use 64X23)
(For revision or removal of integrated neurostimulator system, subfascial posterior tibial nerve, use 64X24)
- 64590 *Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver; requiring pocket creation and connection between electrode array and pulse generator or receiver*
(Do not report 64590 in conjunction with 64595, 64596, 64597, 64598, 1013T)
(For insertion or replacement of percutaneous electrode array with integrated neurostimulator; use 64596)
(For neurostimulators without a named target nerve [eg, field stimulation], use 64999)
(For open implantation or replacement of integrated neurostimulator system, subcutaneous posterior tibial nerve, use 64X21)
(For open implantation or replacement of integrated neurostimulator system, subfascial posterior tibial nerve, use 64X22)
- 64596 *Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator; including imaging guidance, when performed; initial electrode array*
- ✚64597 *each additional electrode array (List separately in addition to code for primary procedure)*
(Use 64597 in conjunction with 64596)
(Do not report 64596, 64597 in conjunction with 64555, 64561, 64590, 64595)
(For percutaneous implantation of electrode array only, peripheral nerve, use 64555)
(For percutaneous electrical nerve field stimulation utilizing noninvasive, non-implanted stimulation of a cranial nerve field [ie, PENFS], use 64567)

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(For implantation of trial or permanent electrode arrays or pulse generators for peripheral subcutaneous field stimulation, use 64999)

(For neurostimulators without a named target nerve [eg, field stimulation], use 64999)

(For percutaneous implantation or replacement of integrated neurostimulation system for bladder dysfunction, posterior tibial nerve, use 0587T)

(For open implantation or replacement of integrated neurostimulator system, subcutaneous posterior tibial nerve, use 64X21)

(For open implantation or replacement of integrated neurostimulator system, subfascial posterior tibial nerve, use 64X22)

~~(For open implantation or replacement of integrated neurostimulator system, posterior tibial nerve, see 0816T, 0817T)~~

64598 *Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator*

(For revision or removal of electrode array only, use 64585)

(For revision or removal of integrated neurostimulation system, posterior tibial nerve, see 64X23, 64X24, 0588T, 0818T, 0819T)

●64X21 Open implantation or replacement of integrated neurostimulation system, posterior tibial nerve, including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed; subcutaneous
(Use 64X21 when the open placement of the neurostimulator is in the subcutaneous layer with or without a component [eg, electrode array] placed into the subfascially)

●64X22 subfascial

(Report 64X21 if an open incision to the fascia is not performed)

(Use 64X22 if the fascia is opened via an incision and the tibial nerve is visualized)

(Do not report 64X22 if an open incision to the fascia is not performed)

(Do not report 64X21, 64X22 in conjunction with [64555], [64575], [64585], [64590], [64596], [64598], 95970, 95971, 95972, 0589T, 0590T)

(For percutaneous implantation or replacement of integrated neurostimulation system including electrode array and receiver for bladder dysfunction, posterior tibial nerve, use 0587T)

(For posterior tibial neurostimulation, percutaneous needle electrode, single treatment, use 64566)

●64X23 Open revision or removal of integrated neurostimulation system, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous

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(Do not report 64X23 in conjunction with 64X21)

●64X24 subfascial

(Do not report 64X24 in conjunction with 64X22)

(Do not report 64X23, 64X24 in conjunction with 64555, 64575, 64585, 64590, 64596, 64598, 95970, 95971, 95972, 0589T, 0590T)

(For revision or removal of percutaneous integrated neurostimulation system for bladder dysfunction, posterior tibial nerve, use 0588T)

Medicine

Neurology and Neuromuscular Procedures

Neurostimulators, Analysis-Programming

95970 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming*

(Do not report 95970 in conjunction with 43647, 43648, 43881, 43882, 61850, 61860, 61863, 61864, 61867, 61868, 61880, 61885, 61886, 61888, 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688, 64553, 64555, 64561, 64X21, 64X22, 64X23, 64X24, 64566, 64568, 64569, 64570, 64575, 64580, 64581, 64582, 64583, 64584, 64585, 64590, 64595, ~~0088T, 0989T~~ 64XXX, 64XX0, during the same operative session)

(Do not report 95970 in conjunction with 95971, 95972, 95976, 95977, 95983, 95984)

Category III Codes

0587T *Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve*

(Do not report 0587T in conjunction with 64555, 64566, 64X21, 64X22, 64575, 64590, 64596, 95970, 95971, 95972, 0588T, 0589T, 0590T, ~~0816T, 0817T~~)

0588T *Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve*

(Do not report 0588T in conjunction with 64555, 64566, 64X23, 64X24, 64575, 64590, 64598, 95970, 95971, 95972, 0587T, 0589T, 0590T, ~~0818T, 0819T~~)

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0816T ——— Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous

0817T ——— subfascial

#0988T ——— subcutaneous and subfascial

(Do not report 0988T in conjunction with 0816T, 0817T)

(Do not report 0816T, 0817T, 0988T in conjunction with 64555, 64566, 64575, 64590, 64596, 95970, 95971, 95972, 0588T, 0589T, 0590T)

(0816T, 0817T, 0988T have been deleted)

(For open implantation or replacement of neurostimulator system, subcutaneous or subfascial posterior tibial nerve, see 64X21, 64X22)

0818T ——— Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous

0819T ——— subfascial

#0989T ——— subcutaneous and subfascial

(Do not report 0989T in conjunction with 64X23, 64X24, 0818T, 0819T)

(Do not report 0818T, 0819T, 0989T in conjunction with 64555, 64566, 64575, 64590, 64596, 95970, 95971, 95972, 0588T, 0589T, 0590T)

(For percutaneous implantation or replacement of integrated neurostimulation system including electrode array and receiver for bladder dysfunction, posterior tibial nerve, use 0587T)

(For revision or removal of percutaneous integrated neurostimulation system for bladder dysfunction, posterior tibial nerve, use 0588T)

(For electronic analysis with programming of integrated or leadless neurostimulation system for bladder dysfunction, posterior tibial nerve, performed on a day subsequent to the device insertion, replacement, or revision, see 0589T, 0590T)

(0818T, 0819T, 0989T have been deleted)

(For revision or removal of neurostimulator system, posterior tibial nerve, see 64X23, 64X24)

Typical Patient (64X21)

A 52-year-old female presents with intractable urge urinary incontinence (UUI). The patient has been treated with conservative remedies, and her UUI remains. In order to achieve desired continence, the physician implants an integrated neurostimulation system via open approach to reduce incontinence.

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Typical Patient (64X22)

A 47-year-old female with intractable and debilitating urinary urge incontinence, has multiple UUI episodes per day associated with multiple daily urgency episodes. All available conservative remedies have been unsuccessful, and patient proceeds to implant of a subfascial integrated tibial nerve neurostimulator.

Typical Patient (64X23)

A 61-year-old female with a previously placed posterior tibial integrated neurostimulator is no longer effective.

Typical Patient (64X24)

A 61-year-old female with a previously placed posterior tibial integrated neurostimulator is no longer effective.

Tab 34-Integrated Tibial Neurostimulator Services

This action will be effective in the CPT 2028 code set.

Tabs 34 and 33 were voted as a single Panel action. See Tab 33 for Panel action.

Tab 35-Hysterosalpingo-foam Sonography

The Panel rejected this request to establish Category I code 76XX1 to report hysterosalpingo-foam sonography for assessing fallopian tube patency.

As rationale for rejection of this request, the Panel noted that the following CPT Criteria have not been met:

General CPT Code Criteria:

B3. The proposed descriptor for the procedure or service is neither a fragmentation of an existing procedure or service nor currently reportable as a complete service by 1 or more existing codes (with the exclusion of unlisted codes).

Specific Criteria For Category I:

C5. The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code-change application.

Tab 36-AI-Multiparametric Quantification-Liver Tissue Composition

The Panel rejected this request to delete Category III codes [0648T], [0649T]; revise [0697T], [0698T] to become parent codes; and establish Category I code 76XX2 to report noninvasive multiparametric liver tissue quantification using quantitative MRI software analysis.

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As rationale for rejection of this request, the Panel noted that the following CPT Criteria have not been met:

General CPT Code Criteria:

B2. The descriptor structure, guidelines and instructions are consistent with current Editorial Panel standards for maintenance of the code set.

Specific Criteria For Category I:

C5. The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code-change application.

Tab 37-Radiation Oncology Treatment Delivery Guidelines

This action will be effective in the CPT 2028 code set.

Tab 37 was extracted from the Final Consent Agenda published 9-11-2026.

The Panel accepted with modifications on-site Option E of this request to revise Radiation Treatment Delivery guidelines to provide clarification and examples regarding intended use of radiation treatment delivery codes.

The Panel modified this request by: (1) revising the guidelines (a) adding the term “an” under Active Motion Management subsection; (b) revising the term “organ” in the first paragraph to be plural; (c) adding the phrase “For techniques employing continuous or real-time imaging (eg, continuous tracking), imaging and treatment delivery may occur concurrently without interruption depending on necessity or with necessary modifications; (d) removing the word “It”, and adding the phrase “Active motion management”; (2) adding a hyphen to the term “set-up”; and (3) deleting the phrase “This is intent of” so the sentence begins with “Active”.

Category I Radiology Radiation Oncology Radiation Treatment Delivery

Following dosimetry calculations, there are a number of alternative methods to deliver external beam radiation treatments, which are described with specific CPT codes:

- *Superficial and orthovoltage X-rays;*
- *Electron beams;*
- *Neutron beams;*
- *Proton beams;*
- *Megavoltage photons.*

Technical

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All treatment delivery codes are reported once per treatment session. The treatment delivery codes recognize technical-only services. ~~The treatment management codes contain the professional component.~~

Professional

Treatment management may be separately reported.

Radiation treatment delivery with conventional X ray or electron beams is assigned levels of complexity based on the number of treatment sites and the complexity of the treatment delivery. Complexity refers to the time and effort of therapists, physicians, and physicists to effect safe delivery. Neither energy of the megavoltage (≥ 1 MeV) beam nor technique (3D, IMRT, or VMAT) contributes to complexity.

Radiation may be delivered to a primary malignant site, to a primary malignant site plus the draining lymph nodes at risk for disease involvement, for palliative care, or benign diseases.

Two-dimensional radiation therapy (2D RT) is delivered with uniform radiation beam intensities and radiation delivery set-up, either by surface anatomic landmarks or bony landmarks with kilovoltage (kV) or MeV imaging. Three-dimensional conformal radiation therapy (3D CRT) uses volumetric imaging to identify targets and organs at risk (OAR). More Conformal conformal beams are often used to avoid normal tissues and decreases risks of side effects. Using volumetric imaging, 3D CRT utilizes computer-based photon beam arrangements to create more conformal dose distributions than 2D RT. ~~More conformal beams are often used to avoid normal tissues and decreases risks of side effects.~~ In both 2D and 3D therapy, a uniform photon beam is used to deliver therapy. 2D RT and 3D CRT differ by complexity of the beam arrangements and identification of target(s) and sparing of OAR.

For 3D conformal radiation therapy, OAR should be identified and radiation dose evaluated using a dose-volume histogram.

Intensity modulated radiation therapy (IMRT) uses computer-based optimization techniques with non-uniform radiation beam intensities to create highly conformal dose distributions that can be delivered by a radiotherapy treatment machine. A number of technologies, including spatially and temporally modulated beams, cylindrical beamlets, dynamic multileaf collimator (MLC), single or multiple fields or arcs (volumetric arc therapy [VMAT]), or compensators, may be used to generate IMRT. The complexity of IMRT varies depending on the area being treated, the number of targets identified, differential doses delivered, or the technique being used.

Image-guided radiation therapy (IGRT) may be used to direct the radiation beam and to observe the target or OAR position prior to treatment delivery, when changing isocenters or other instances when imaging is done for verification of the target or position of the OAR. For image-guided therapy, treatment delivery may be interrupted for imaging, with delivery resumed with or without modifications as necessary. A variety of techniques may be used to perform this guidance, including imaging (eg, ultrasound, CT, MRI, stereoscopic X-ray imaging) and other techniques (eg, electromagnetic or infrared). Guidance may be used with any radiation treatment delivery technique. Because only the technical portion of IGRT is bundled into radiation treatment delivery (77402, 77407, 77412), the physician involvement in guidance or tracking may be reported separately.

Isocenter

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An isocenter is the reference point in the treatment machine's coordinate system to which the patient is positioned for treatment delivery. A planned shift to a different reference point for an additional treatment volume constitutes an additional isocenter and increases treatment complexity.

As a starting point, the patient is positioned as specified in the plan to the reference point of the treatment machine's coordinate system (hereinafter identified by the term “isocenter”). Prior to treatment delivery, the patient's position relative to the isocenter requires image verification. If a shift in the patient's position relative to the isocenter is necessary for additional treatment volumes, as described in the patient isodose plan(s), this would be a second isocenter.

Active Motion Management

Active motion management involves monitoring and managing physiologic motion of the target or organs at risk (OAR) during treatment delivery (eg, during a deep inspiration breath hold, pre-defined serial intra-fraction imaging, movement of the prostate with bladder or rectal filling, bowel peristalsis that alters the position of the target or OAR). For techniques employing continuous or real-time imaging (eg, continuous tracking), imaging and treatment delivery may occur concurrently without interruption depending on necessity or with necessary modifications. Active motion management may include gating, surface guidance, fiducial tracking, or imaging used during delivery. Initial patient positioning or isocenter verification alone does not constitute active motion management. When active motion management is performed, report Level 3 treatment delivery. The medical record must identify the target or OAR being managed and the technique used.

Treatment delivery with active motion management (77412) includes intra-fraction localization and tracking of the target(s), or patient motion to optimize beam delivery (eg, intra-fraction motion, surface guidance).

Intra-fraction motion management utilizes fiducials or imaging to monitor the target or organs at risk during the breathing cycle (eg, during a deep inspiration breath hold). This method minimizes organ motion and allows more accurate delivery of radiation to mobile targets and active avoidance of OAR.

Note: Active motion management may also take place after initial IGRT for patient set-up and confirmation of isocenter position.

Surface Guidance

Surface guidance for active motion management is a technique that allows the linear accelerator to perform gating (eg, optical) during treatment delivery using the body surface contour as a surrogate for target localization, internal target motion and OAR avoidance. Surface guidance is one method to effect active motion management, although there are other methods as well.

Note: This is Active motion management is **not** for patient set-up prior to treatment delivery (eg, not to replace tattoos).

Tab 38-Bone Marrow Biopsy-Revise 88305 88307-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

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Tab 39-MAAA-Oncology-Breast-Delete 81520

This action will be effective in the CPT 2028 code set.

Tab 39 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted this request to: (1) delete Multianalyte Assays with Algorithmic Analyses (MAAA) code 81520 for reporting breast cancer recurrence risk score; and (2) add parenthetical notes to reflect these changes.

Category I

Pathology and Laboratory

Multianalyte Assays with Algorithmic Analyses

81520 — ~~Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score~~
(81520 has been deleted)

Appendix O

Multianalyte Assays with Algorithmic Analyses

Proprietary Name and Clinical Laboratory or Manufacturer	Alpha-Numeric Code	Code Descriptor
~~Prosigna® Breast Cancer Assay, NanoString Technologies, Inc~~	~~81520~~	~~Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score~~
	(81520 has been deleted)	

Tab 40-Blood Bank Physician Services

This action will be effective in the CPT 2028 code set.

Tab 40 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted this request to: (1) delete code 86077; (2) revise code 86078 to add “or transfused/infused biologic product(s)”, add a comma after “reaction”, and remove “including suspicion of transmissible disease,”; (3) revise code 86079 to add “or other cellular therapy” and deleting the parenthetical “(eg, use of outdated blood, transfusion of Rh incompatible units),”; (4) establish codes 86XX2, 86XX3, and 86XX4 for reporting blood bank physician services; and (5) add a deletion parenthetical note to direct users to codes 86XX2 and 86XX3.

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**Category I
Pathology and Laboratory
Immunology**

- ~~86077~~ ~~Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report~~
(86077 has been deleted. To report, see 86XX2, 86XX3)
- 86XX2 Blood bank, cellular therapy, and histocompatibility physician services; evaluation of difficult cross match of <3 irregular antibody(ies) or antigen(s), interpretation and ~~written~~ report
 - 86XX3 evaluation of pan-reactive antibodies (including therapeutic antibody [eg, daratumumab]) or difficult cross match of multiple (≥ 3) irregular antibodies or antigen(s), including molecular typing/genotyping result(s), when performed, interpretation and ~~written~~ report
 - 86XX4 transplant (solid organ or stem cell) or cellular/gene therapy evaluation to provide recommendations for transfusion support before, during, or after transplant or cellular biologic product(s) infusion, with ~~written~~ report
 - ▲86078 investigation of transfusion or transfused/infused biologic product(s) reaction, including suspicion of transmissible disease, interpretation and ~~written~~ report
 - ▲86079 authorization for deviation from standard blood banking or other cellular therapy procedures (eg, use of outdated blood, transfusion of Rh incompatible units), with ~~written~~ report
(*Brucella, antibodies to, use 86622*)
(*Candida, antibodies to, use 86628. For skin testing, use 86485*)

Typical Patient (86XX2)

A 30-year-old female presenting for preoperative evaluation has a positive antibody screen requiring additional testing for provision of compatible red blood cells.

Description of Procedure (86XX2)

Obtain and review history and diagnostic studies, including previously performed internal and external laboratory results. Evaluate and interpret the antibody screen, panel, and any additional accompanying laboratory data. Compare current findings to previous laboratory results. Determine the clinical significance of serologic findings in conjunction with literature review, as applicable. Determine the best antibody identification compatibility and crossmatch techniques. Select appropriate blood components. Prepare ~~a written~~ report.

Typical Patient (86XX3)

A 13-year-old female with sickle cell disease has a positive antibody screen, with multiple red blood antibodies requiring additional testing to identify compatible blood for a transfusion.

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Description of Procedure (86XX3)

Obtain and review history and diagnostic studies, including previously performed internal and external laboratory results, including molecular results for red cell antigens. Evaluate and interpret the antibody screen, panel, and any additional accompanying laboratory data. Compare current findings to previous laboratory results. Determine the clinical significance of serologic findings in conjunction with literature review. Determine the best antibody identification compatibility and crossmatch techniques. Select appropriate blood components. Prepare a written report. Communicate findings and recommendations with applicable health professionals. Arrange for additional studies or other services.

Typical Patient (86XX4)

Pretransplant evaluation of a 15-year-old male with acute leukemia with a history of multiple blood transfusions who may have RBC alloantibodies. Of note, his donor is ABO incompatible with his ABO type.

Description of Procedure (86XX4)

Obtain and review history and diagnostic studies, including previously performed internal and external laboratory results, including molecular results for red cell antigens. Evaluate and interpret the blood type, antibody screen, panel, and any additional accompanying laboratory data. Compare current findings to previous laboratory results. Determine the clinical significance of serologic findings and blood type discrepancies in conjunction with literature review. Determine the best antibody identification compatibility and crossmatch techniques. Select appropriate blood components for the pre, intra, and post transplant/therapy periods. Prepare a written report. Communicate findings and recommendations with applicable health professionals. Arrange for additional studies or other services.

Typical Patient (86078)

Evaluation of a 70-year-old male who developed symptoms suggestive of a potential transfusion reaction during the course of transfusion of a unit of red blood cells.

Description of Procedure (86078)

Assessment of patient status, vital signs, laboratory values, and post-transfusion blood sample blood bank evaluation, radiology studies, transfusion history, blood product test results (eg, gram smear, repeat blood type) and medication administration history when applicable. Order additional laboratory studies as indicated. Determine transfusion reaction type. Prepare a written report. Communicate findings and recommendations with applicable health professionals, including recommendations for treatment, and recommendations related to future transfusions. Prepare a written report. Arrange for additional studies or other services.

Typical Patient (86079)

A 65-year-old O negative blood type female with myelodysplastic syndrome presents with bleeding and need for multiple red cell and platelet transfusions, with limited type specific red blood cell units and platelets available in the blood bank for transfusion.

Description of Procedure (86079)

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Clinical assessment of the patient at presentation, transfusion history, transfusion requirements history, availability of blood products and timing of current blood type and antibody work up, urgency of the requested transfusion. Determining best possible blood available to be provided and making this recommendation to the clinical team caring for the patient as needed. Prepare a written report. Communicate findings and recommendations with applicable health professionals. Arrange for additional studies or other services.

Tab 41-Infectious Agent Detection-Adenovirus

This action will be effective in the CPT 2028 code set.

Tab 41 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted this request to establish codes 87XX3, 87XX4 for reporting infectious agent detection of nucleic acid by amplified probe technique or by quantification.

Category I Pathology and Laboratory Microbiology

87468 *Infectious agent detection by nucleic acid (DNA or RNA); Anaplasma phagocytophilum, amplified probe technique*

#●87XX3 adenovirus, amplified probe technique

#●87XX4 adenovirus, quantification

Typical Patient (87XX3)

An 8-year-old male develops fever, chills, respiratory distress, and diarrhea at 1 month after allogeneic hemopoietic stem-cell transplantation for refractory acute lymphocytic leukemia. Nasopharyngeal swab, stool, and plasma specimens were collected for qualitative adenovirus PCR test.

Description of Procedure (87XX3)

Clinical specimens obtained undergo viral nucleic acid extraction and purification, followed by amplification and detection of adenoviral DNA. A qualitative result is reported.

Typical Patient (87XX4)

A 35-year-old male with long-standing type 1 diabetes mellitus develops fever, chills, respiratory distress, and mental confusion at 3 months after pancreatic transplantation. Qualitative adenoviral DNA was positive in nasopharyngeal swab. Plasma specimen was collected for quantitative adenovirus PCR test.

Description of Procedure (87XX4)

Plasma sample obtained undergoes viral nucleic acid extraction and purification, followed by amplification, detection, and quantification of adenoviral DNA present. A quantitative result (ie, viral load) is reported.

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Tab 42-Sensorineural Acuity Test-Del 92575

This action will be effective in the CPT 2028 code set.

Tab 42 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted this request to: (1) delete Category I code 92575; and (2) add a parenthetical note instructing users to code 92700 for testing of sensorineural acuity level.

Category I

Medicine

Special Otorhinolaryngologic Services

Audiologic Function Tests

92575 ——— Sensorineural acuity level test

(92575 has been deleted. To report testing of sensorineural acuity level, use 92700)

Tab 43-Intraoperative Monitoring-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 44-Medical Nutrition Therapy (MNT)

This action will be effective in the CPT 2028 code set.

Tab 44 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted Option C of this request to: (1) revise codes 97802, 97803, 97804 to report medical nutrition therapy, primary episode; (2) establish codes 97X01, 97X02 to report medical nutrition therapy, secondary episode; (3) add new guidelines under Medical Nutrition Therapy to guide users on correct use of these codes; (4) revise guidelines throughout the code set to include new codes; and (5) revise cross-reference parenthetical notes under codes 99509, 0592T to include new codes.

Category I

Medicine

Behavior Management Services

Behavior modification is defined as ...

...

Medical nutrition therapy (97802, 97803, 97804, 97X01, 97X02) provided to the identified patient may be reported on the same date of service as parent(s)/guardian(s)/caregiver(s) training service.

...

Medical Nutrition Therapy

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Medical nutrition therapy (MNT) is defined as the provision of any of the following nutrition care services for the purpose of management or treatment of a disease or medical condition:

- nutrition assessment;
- nutrition diagnosis;
- nutrition intervention; and
- nutrition monitoring and evaluation.

Physicians and other qualified health care professionals (QHP) who may report evaluation and management services should use the appropriate evaluation and management codes to report medical nutrition therapy services.

Episode: For MNT services, an episode is defined as beginning when the MNT is initiated for a diagnosis or medical condition and ends with attainment and maintenance of clinical nutrition goals.

Primary Episode: Includes the initial, re-assessment, and group MNT encounters for a diagnosis, medical condition, treatment regimen, or plan of care that remains substantially unchanged. For example: A patient with type 2 diabetes is initially managed with oral medications and an individualized meal plan that supports glycemic control.

Secondary Episode: Begins when the physician or other QHP determines that a clinically significant change in the patient's diagnosis, medical condition, treatment regimen, or plan of care warrants re-assessment and modification of medical nutrition therapy. For example: During the course of MNT treatment the patient develops worsening glycemic control requiring the patient changing from oral agents to basal-bolus insulin including development of a new insulin-to-carbohydrate education plan, hypoglycemia prevention counseling, and revised meal timing.

- ★▲▲97802 Medical nutrition therapy; primary episode, initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- ★▲▲97803 primary episode, re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- ★▲▲97804 primary episode, group (2 or more individual(s)), each 30 minutes
- ★●●97X01 secondary episode, re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- ★●●97X02 secondary episode, group (2 or more individuals), each 30 minutes

(Physicians and other qualified health care professionals who may report evaluation and management services should use the appropriate evaluation and management codes)

Education and Training for Patient Self-Management

The following codes are used ...

...

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(For counseling and/or risk factor reduction intervention provided by a physician to patient[s] without symptoms or established disease, see 99401-99412)

(For medical nutrition therapy, see 97802, 97803, -97804, 97X01, 97X02)

(For health behavior assessment and intervention that is not part of a standardized curriculum, see 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171)

...

Non-Face-to-Face Nonphysician Qualified Health Care Professional Services Remote Therapeutic Monitoring Treatment Management Services

Do not count any time ...

Do not count any time directly related to other reported services (eg, psychotherapy services [90832, 90833, 90834, 90836, 90837, 90838], interrogation device evaluation services [93290], anticoagulant management services [93793], respiratory monitoring services [94774, 94775, 94776, 94777], health behavior assessment and intervention services [96156, 96158, 96159, 96160, 96161, 96164, 96165, 96167, 96168, 96170, 96171], therapeutic interventions that focus on cognitive function services [97129, 97130], adaptive behavior treatment services [97153, 97154, 97155, 97156, 97157, 97158], therapeutic procedures [97110, 97112, 97116, 97530, 97535], tests and measurements [97750, 97755], physical therapy evaluation services [97161, 97162, 97163, 97164], occupational therapy evaluations [97165, 97166, 97167, 97168], orthotic management and training and prosthetic training services [97760, 97761, 97763], medical nutrition therapy services [97802, 97803, 97804, 97X01, 97X02], medication therapy management services [99605, 99606, 99607], critical care services [99291, 99292], principal care management services [99424, 99425, 99426, 99427]) in the cumulative time of the remote therapeutic monitoring treatment management service during the calendar month of reporting.

Home Health Procedures/Services

99509 *Home visit for assistance with activities of daily living and personal care*

(To report self-care/home management training, see 97535)

(To report home medical nutrition assessment and intervention services, see 97802, 97803, -97804, 97X01, 97X02)

(To report home speech therapy services, see 92507-92508)

Category III Codes Health and Well-Being Coaching

0591T *Health and well-being coaching face-to-face; individual, initial assessment*

0592T *individual, follow-up session, at least 30 minutes*

(Do not report 0592T in conjunction with 96156, 96158, 96159, 98960, 0488T, 0591T)

(For medical nutrition therapy, see 97802, 97803, 97804, 97X01, 97X02)

Typical Patient (97802)

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A 55-year-old female with type 2 diabetes presents for initial medical nutrition therapy for the development of a nutrition care plan to support treatment and management of their condition.

Typical Patient (97803)

A 55-year-old female with type 2 diabetes presents for follow-up medical nutrition therapy to monitor progress and adjust the nutrition care plan based on the response to treatment and ongoing clinical needs.

Typical Patient (97804)

A 55-year-old female with type 2 diabetes presents for follow-up medical nutrition therapy to monitor progress and adjust the nutrition care plan based on the response to treatment and ongoing clinical needs.

Typical Patient (97X01)

A 55-year-old female with type 2 diabetes presents for additional medical nutrition therapy following a change in health status requiring adjustments to the nutrition care plan to address current clinical needs.

Typical Patient (97X02)

A 55-year-old female with type 2 diabetes presents for additional medical nutrition therapy following a change in health status requiring adjustments to the nutrition care plan to address current clinical needs.

Tab 45-Continuous Glucose Monitoring

The Panel postponed until time uncertain this request to: (1) revise guidelines; (2) revise codes 95249-95251; and (3) establish Category I code 95X12 to report advances in diabetes technology using continuous glucose monitoring.

As a rationale for postponement, the Panel instructed that the following issues be addressed:

1. Include a better characterization of evaluation and management, remote therapeutic monitoring, and remote therapeutic monitoring management services within the instructions (ie, guidelines and parenthetical notes) and descriptor language;
2. Identify how often a data query may occur (to address questions regarding deletion of exclusion instructions that provided guidance regarding restriction from reporting the procedure more than once/day);
3. If continuous glucose monitoring data queries are performed more than once/day, identify the timeframe that should be used for instruction;
4. Identify how non-face-to-face efforts may be captured;
5. Address RUCs concerns regarding identifying components that need to be separately reportable for continuous glucose monitoring services (ie, address differentiating the increase in reporting codes 95249-95251);
6. Include typical patient content that accurately represents the patient that would best represent these services as they are currently performed; AND

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7. Include descriptions of procedure for each code that focus on the work done for each service.

Tab 46-AI-Noninvasive Arrhythmia Analysis Services

This action will be effective in the CPT 2028 code set.

The Panel accepted with modifications on-site Option C of this request to: (1) establish code 93XX7 to report noninvasive arrhythmia localization mapping derived by augmentative algorithmic analysis of 12-lead ECG and clinical parameters with physician iterative interaction and automated result; (2) add a conditional exclusionary parenthetical note restricting use of code 93XX7 with codes 93000, 93005, and 93010; (3) revise the Cardiography guidelines; (4) delete Category III code 0897T and its related parenthetical note; (5) add a deletion parenthetical note for code 0897T; and (6) add a cross-reference parenthetical note directing to code 93XX7.

The Panel modified the request by: (1) removing the localization mapping definition and revising the iterative interaction definition in the guidelines; and (2) revising the descriptor for code 93XX7 by: (a) adding the term “ventricular” after “noninvasive”; (b) removing the term “localization”; (c) adding the phrase “with software” after “interaction”; and (d) removing the phrase “automated result”.

Category I Medicine Cardiovascular Cardiography

Codes 93040-93042 are appropriate when an order for the test is triggered by an event, the rhythm strip is used to help diagnose the presence or absence of an arrhythmia, and a report is generated. There must be a specific order for an electrocardiogram or rhythm strip followed by a separate, signed, written, and retrievable report. It is not appropriate to use these codes for reviewing the telemetry monitor strips taken from a monitoring system. The need for an electrocardiogram or rhythm strip should be supported by documentation in the patient medical record.

Cardiac arrhythmias often originate from or are sustained by specific regions of the heart.

Iterative interaction is the recursive use of mapping software in which the physician enters patient-specific clinical parameters, selects the applicable arrhythmia analysis, and selects representative ECG cycles or intervals for analysis.

[93040] *Rhythm ECG, 1-3 leads; with interpretation and report*

[93041] *tracing only without interpretation and report*

[93042] *interpretation and report only*

#●93XX7 Noninvasive ventricular arrhythmia mapping derived by augmentative algorithmic analysis of 12-lead electrocardiogram and clinical parameters (eg, prior ablation, chamber dilation, scar distribution), with physician iterative interaction with software

(Do not report 93XX7 in conjunction with [93000], [93005], [93010], when performed on the same day)

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Category III Codes

[0897T] — Noninvasive augmentative arrhythmia analysis derived from quantitative computational cardiac arrhythmia simulations, based on selected intervals of interest from 12-lead electrocardiogram and uploaded clinical parameters, including uploading clinical parameters with interpretation and report

(Do not report [0897T] in conjunction with [93000], [93005], [93010], when performed on the same day)

([0897T] has been deleted)

(For noninvasive ventricular augmentative arrhythmia mapping analysis derived from by augmentative algorithmic analysis of quantitative computational cardiac arrhythmia simulations, based on selected intervals of interest from 12-lead electrocardiogram and uploaded clinical parameters, including uploading clinical parameters, with interpretation and report, use 93XX7)

Typical Patient (93XX7)

A 67-year-old female with frequent symptomatic ventricular tachycardia experiences syncope and multiple implantable cardioverter-defibrillator shocks despite escalating antiarrhythmic drug therapy. Given the progressive change in symptom severity and frequency, her physician decides to perform noninvasive arrhythmia localization mapping to identify candidate regions for procedural investigation and possible targeted ablation.

Tab 47- Extended Psychotherapy Services-Rev 90834 90837-Terminated

This issue was terminated by AMA Staff prior to the meeting.

Tab 48-AI-Left Ventricular End-Diastolic Pressure Measurement

The Panel rejected this establish code 93XX6 for reporting noninvasive measurement of left ventricular end-diastolic pressure for detection of heart failure derived from augmentative analysis of simultaneous electrocardiogram recording and arterial hemodynamic waveforms.

As rationale for rejection of this request, the Panel noted that the following CPT Criteria have not been met:

General CPT Criterion:

B2: The descriptor structure, guidelines and instructions are consistent with current Editorial Panel standards for maintenance of the code set.

Category I-specific Criterion:

C2: The procedure or service is performed by many physicians or other qualified health care professionals across the United States.

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Tab 49-AI-Electrical Impedance Spectroscopy Analysis-Skin Lesions

The Panel rejected this request to: (1) establish two Category I codes 96XX0, 96XX1 and corresponding parenthetical notes reporting electrical impedance spectroscopy; and (2) delete Category III code 0658T.

As rationale for rejection of this request, the Panel noted that the following CPT Criteria have not been met:

General CPT Criterion:

B1: The proposed descriptor is unique, well-defined, and describes a procedure or service which is clearly identified and distinguished from existing procedures and services already in CPT.

Specific Criteria For Category I:

C3: The procedure or service is performed with frequency consistent with the intended clinical use (i.e., a service for a common condition should have high volume).

Tab 50-Supervised Self-administration-Intranasal Esketamine

This action will be effective in the CPT 2028 code set.

Tab 50 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted Option D of this request to: (1) establish code 908X1 for reporting esketamine nasal self-administration that requires supervision of a physician or other qualified health care professional including two hours or more post-administration observation; and (2) add three instructional parenthetical notes on the appropriate reporting of 908X1.

Category I Medicine Psychiatry Psychiatric Diagnostic Procedures Other Psychiatric Services or Procedures

90865 *Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital (Amytal) interview)*

●908X1 Esketamine nasal self-administration that requires the supervision of a physician or other qualified health care professional, including 2 hours or more post-administration observation

(Code 908X1 does not include provision of esketamine, which is otherwise supplied by the physician or other qualified healthcare professional, and which is separately reported)
(Report supply of esketamine separately)

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(908X1 does not include provision of esketamine which is otherwise supplied by the physician or qualified healthcare professional)

(If a significant, separately identifiable evaluation and management service is performed the appropriate E/M service may be separately reported using the appropriate E/M code with modifier 25)

Typical Patient (908X1)

A 42-year-old female with recurrent major depressive disorder (MDD) has struggled with persistent symptoms of low mood, loss of interest in daily activities, and fatigue for over five years. After trials of two antidepressants and psychotherapy, symptoms have persisted which reflect criteria for treatment-resistant depression.

Tab 51-Provocation Testing-Revise 93024-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 52-Optical Coherence Tomography, Middle Ear-Withdrawn

This issue was withdrawn by the requestor during the Panel meeting.

Tab 53-Repetitive Transcranial Magnetic Stimulation-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 54-AI Algorithmic Acoustic and ECG Analysis-Withdrawn

This issue was withdrawn by the requestor during the Panel meeting.

Tab 55-Medical Testimony

The Panel rejected this request to revise Category I code [99075](#) and to add a new code (990XX) to include a time component for report medical-legal document review and preparation for testimony.

As rationale for rejection of this request, the Panel noted that the following CPT Criteria have not been met:

General CPT Criterion:

B2: The descriptor structure, guidelines and instructions are consistent with current Editorial Panel standards for maintenance of the code set.

Specific Criterion For Category I Codes:

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C5: The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code-change application.

Tab 56-Cat III-Slipped Rib Stabilization

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tab 56 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted this request to: (1) establish Category III code X699T to report open treatment of a slipped rib; and (2) add an exclusionary parenthetical note to restrict use of this code in conjunction with strapping (29200), injection of anesthetic (64420, 64421), or paravertebral block injection of the thorax (64461).

Category III Codes

- X699T Slipped rib(s) stabilization with internal fixation, unilateral, 1-4 ribs
 (Do not report X699T in conjunction with 29200, 64420, 64421, 64461)

Typical Patient (X699T)

A 20-year-old female presented with anterior chest wall pain. The pain is neuropathic and spasmodic in nature and radiates from the lower anterior chest to the back. Pain is constant and severe. There is a click in the costochondral region that triggers pain. Hook maneuver and dynamic ultrasound is positive for cartilage subluxation of the 10th rib consistent with slipping rib syndrome.

Description of Procedure (X699T)

After inducing general anesthesia, the surgical team identifies and marks the area of rib abnormality. The surgeon localizes the unstable 10th and stable 9th ribs, with image guidance when necessary. An incision is made and dissection is performed through the fascia and oblique muscles to access the chest wall. The 9th rib is cleaned, and the sharp tip of the unstable 10th rib is mobilized. Cartilage is excised or shaped as needed. The 10th rib is advanced cephalad. Using non-absorbable sutures, the 10th rib was secured on top of the 9th rib, eliminating its mobility. Hemostasis is confirmed. Intercostal nerve blocks are administered with or without placement of catheters for postoperative pain management with local anesthetic(s), and the wound is closed in layers. A sterile dressing is applied. The patient is transferred to recovery in stable condition.

Tab 57-Cat III-Transcranial Photobiomodulation-Psychiatric

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tab 57 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted this request to establish Category III code X697T for reporting transcranial photobiomodulation therapy.

Category III Codes

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- X697T Transcranial photobiomodulation therapy, delivery and management, per session

Typical Patient (X697T)

A 44-year-old male with major depressive disorder has failed to improve despite trials of multiple medications across therapeutic classes. Following a discussion of treatment options, transcranial photobiomodulation therapy targeting the dorsolateral prefrontal cortex is recommended.

Description of Procedure (X697T)

The physician activates the transcranial photobiomodulation system, delivering near-infrared energy to the targeted dorsolateral prefrontal cortical regions according to the prescribed treatment parameters while continuously monitoring the patient throughout the treatment.

Tab 58-Cat III-AI Spine and Orthopedic Surgical Simulation-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 59-Cat III-AI ECG Risk-based Assessment-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 60-Cat III-3D Volumetric Measurement for Lymphedema Assessment

The Panel postponed until time certain February 2027 this request to establish Category III code X677T for reporting quantitative 3D volumetric and circumferential assessment for lymphedema surveillance and monitoring.

As a rationale for postponement, the Panel instructed that the following issues be addressed:

1. Add appropriate exclusionary parentheticals restricting reporting with codes 1030T and 1033T.
2. Cross-Reference regarding 1030T/1032T
3. Consider if acquisition of imaging should be included in the code.
4. Work with specialty societies and interested parties when refining the CCA for submission in February.

Tab 61-Cat III-Histotripsy-Prostate Tissue-Withdrawn

This issue was withdrawn by the requestor during the Panel meeting.

Tab 62-Cat III-Cold Therapy of Ocular Surface

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

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Tab 62 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted this request to: (1) establish Category III code X698T to report transconjunctival cooling probes to the long ciliary nerves for ocular pain; and (2) add an instructional parenthetical note to instruct users on how to report code X698T as a bilateral procedure.

Category III Codes

- X698T Transconjunctival application of cooling probes to the long ciliary nerves ~~for~~ to control of ocular pain, unilateral

(For bilateral procedure, report X698T with modifier 50)

Typical Patient (X698T)

A 50-year-old female complains of burning, stinging, and aching in both eyes for more than 3 months. Topical medications have not relieved her discomfort. The patient reports 6 of 10 pain and limitations of activities of daily living. There is epiphora and fluorescein staining of the corneal epithelium. A topical anesthetic reduces pain significantly. Chronic ocular surface pain with peripheral sensitization is diagnosed and she is referred for cold therapy of the ocular surface in one eye and subsequently performed in the contralateral eye at a later date.

Description of Procedure (X698T)

The patient is placed in supine position. Anesthetics are applied to the ocular surface. A speculum is positioned on the eye to open the lids. A corneal shield is positioned. The cold device is placed on the eye and the cooling probes brought in contact with the conjunctiva at 3 o'clock and 9 o'clock for about 4 minutes. The ocular surface is then rinsed with room temperature saline solution. The cold therapy device, speculum, and corneal shield are removed. Lubricating ointment is applied.

Tab 63-Cat III-Percutaneous Endovascular Non-balloon Micro-incision

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tab 63 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted Option B of this request to: (1) establish add-on code X714T to report percutaneous transluminal endovascular microincisions, peripheral dialysis segment; and (2) add an inclusionary parenthetical note following code X714T.

Category III Codes

- ✚●X714T Percutaneous transluminal endovascular microincision(s), peripheral dialysis segment (List separately in addition to code for primary procedure)

(Use X714T in conjunction with 36902, 36903, 36905, 36906)

Typical Patient (X714T)

A 66-year-old male with end stage renal disease, diabetes, and hypertension, and over three years of chronic hemodialysis presents with a dysfunctional AV fistula due to angiography-confirmed significant

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peripheral segment stenosis. Percutaneous transluminal endovascular micro-incision is required prior to percutaneous transluminal angioplasty to modify the lesion to optimize restoration of durable luminal patency. [Note: This is an add-on service. Only consider the additional work related to surgeon performance of percutaneous transluminal endovascular micro-incision.]

Description of Procedure (X714T)

In preparation for percutaneous transluminal angioplasty, the physician obtains vascular access and performs the diagnostic angiography necessary to identify and characterize the stenotic lesion in the peripheral dialysis segment. After the physician has placed a 0.018" guidewire across the lesion, an endovascular micro-incision device is then introduced and positioned under fluoroscopic guidance. Using controlled mechanical pullback, the physician creates longitudinal micro-incisions within the stenotic tissue to modify the lesion and increase vessel compliance. This pullback is done multiple times to ensure the entire circumference of the lesion is covered. After lesion modification is completed, the guiding catheter is inserted over the guidewire to exchange the wire for a 0.035" guidewire. Percutaneous transluminal angioplasty of the treated segment is then performed, including completion imaging is then performed to evaluate the treatment result.

Tab 64-Cat III-Non-invasive Intracranial Pressure Sensor Interrogation-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 65-Cat III-Intraoperative Motor Nerve ID and Functional Assessment

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

The Panel accepted with modifications Option B of this request to: (1) establish Category III code X684T reporting intraoperative electrical stimulation (2) add a parenthetical note following 95941 regarding correct use for code X684T; and (3) add an instructional parenthetical note following code X684T regarding correct use of continuous intraoperative neurophysiology monitoring.

The Panel modified this request by revising X684T by moving the term "motor" and adding the terms "(or mixed)".

Category I

Medicine

Neurology and Neuromuscular Procedures

Intraoperative Neurophysiology

#**95940** *Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)*

(Use 95940 in conjunction with the study performed, 92653, 95822, 95860-95870, 95907-95913, 95925, 95926, 95927, 95928, 95929, 95930-95937, 95938, 95939)

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#**+**95941 *Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)*

(Use 95941 in conjunction with the study performed, 92653, 95822, 95860-95870, 95907-95913, 95925, 95926, 95927, 95928, 95929, 95930-95937, 95938, 95939)

(For time spent waiting on standby before monitoring, use 99360)

(For electrocorticography, use 95829)

(For intraoperative EEG during nonintracranial surgery, use 95955)

(For intraoperative functional cortical or subcortical mapping, see 95961-95962)

(For intraoperative neurostimulator programming, see 95971, 95972, 95976, 95977, 95983, 95984)

(For surgeon performed intraoperative electrical stimulation of peripheral or cranial motor nerve[s], use X684T)

Category III Codes

+●X684T Intraoperative electrical stimulation of motor (or mixed) peripheral or cranial nerve(s), surgeon performed, for nerve identification, localization, and functional assessment, per operative session (List separately in addition to code for primary procedure)

(Use X684T in conjunction with surgical procedures where motor or motor-sensory nerves may be compromised)

(For continuous intraoperative neurophysiology monitoring reported by a separate neurophysiology professional, see 95940, 95941)

Typical Patient (X684T)

A 72-year-old male is taken to the operating room for repair of a deep laceration of the proximal forearm. During cleaning and exploration of the wound, a possible injury to the exposed ulnar nerve is identified. Nerve testing is performed to evaluate motor nerve function. [**Note:** This is an add-on service. Only consider the additional work related to intraoperative motor nerve identification and functional assessment.]

Description of Procedure (X684T)

Following exposure of the operative field, the surgeon applies an intraoperative nerve stimulator to the nerve or surrounding tissue at one or more anatomic locations. The surgeon selects stimulation parameters (pulse duration, and amplitude), which are confirmed on the device display, and delivers electrical stimulation to the target nerve. The surgeon makes a direct visual observation of evoked muscle contraction and interprets this response in the context of the operative findings to determine nerve identity, assess nerve viability, and differentiate nerve from surrounding tissue. Based on the response to nerve stimulation, the surgeon decides to pursue an alternative repair strategy. This process is repeated at multiple points during the procedure as the operative field evolves.

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Tab 66-Cat III-Occlusion w Catheter Seclusion-Incompetent Vein-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 67-Cat III-Cardiac Conduction-guided Intervention (CGI)

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

The Panel accepted with modification this request to: (1) establish Category III code X678T for reporting registration of a previously generated patient-specific CTA-derived 2D/3D model of the cardiac conduction system to intraprocedural imaging; (2) add code X678T to the exclusionary parenthetical notes following codes 76376 and 76377; and (3) add three parenthetical notes following code X678T regarding the appropriate reporting of the new code.

The Panel modified the request by replacing “and/or” with a comma in the code descriptor.

Category I

Radiology

Diagnostic Radiology (Diagnostic Imaging)

Other Procedures

76376 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation*

(Use 76376 in conjunction with code[s] for base imaging procedure[s])

(Do not report 76376 in conjunction with 31627, 34839, 70471, 70472, 70473, 70496, 70498, 70544, 70545, 70546, 70547, 70548, 70549, 70560, 70561, 70562, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74174, 74175, 74185, 74261, 74262, 74263, 75557, 75559, 75561, 75563, 75565, 75571, 75572, 75573, 75574, 75577, 75635, 76377, 77046, 77047, 77048, 77049, 77061, 77062, 77063, 78012-78999, 93319, 93355, ~~0523T~~, 0559T, 0560T, 0561T, 0562T, 0633T, 0634T, 0635T, 0636T, 0637T, 0638T, 0710T, 0711T, 0712T, 0713T, 0876T, 1030T, 1031T, 1032T, 1033T, 1034T, 1035T, 1086T, 1087T, X668T, X669T, X678T)

(For noninvasive arterial plaque analysis using software processing of data from computerized tomography angiography to quantify structure and composition of the vessel wall, including assessment for lipid-rich necrotic core plaque, see 0710T, 0711T, 0712T, 0713T)

76377 *requiring image postprocessing on an independent workstation*

(Use 76377 in conjunction with code[s] for base imaging procedure[s])

(Do not report 76377 in conjunction with 34839, 70471, 70472, 70473, 70496, 70498, 70544, 70545, 70546, 70547, 70548, 70549, 70560, 70561, 70562, 71275, 71555, 72159,

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72191, 72198, 73206, 73225, 73706, 73725, 74174, 74175, 74185, 74261, 74262, 74263, 75557, 75559, 75561, 75563, 75565, 75571, 75572, 75573, 75574, 75577, 75635, 76376, 77046, 77047, 77048, 77049, 77061, 77062, 77063, 78012-78999, 93319, 93355, ~~0523T~~, 0559T, 0560T, 0561T, 0562T, 0633T, 0634T, 0635T, 0636T, 0637T, 0638T, 0710T, 0711T, 0712T, 0713T, 0876T, 1030T, 1031T, 1032T, 1033T, 1034T, 1035T, 1086T, 1087T, X668T, X669T, X678T)

(76376, 76377 require concurrent supervision of image postprocessing 3D manipulation of volumetric data set and image rendering)

(For noninvasive arterial plaque analysis using software processing of data from computerized tomography angiography to quantify structure and composition of the vessel wall, including assessment for lipid-rich necrotic core plaque, see 0710T, 0711T, 0712T, 0713T)

Category III Codes

- X678T Registration of a previously generated, patient-specific computed tomography angiography (CTA)-derived 2D/3D model of the cardiac conduction system to intraprocedural imaging (eg, fluoroscopy, ultrasound), including continuous monitoring and adjustment of registration throughout the procedure

(Use X678T in conjunction with [33202]-[33220], [33224], [33225], [33226], [33249], [33250], [33251], [33254], [33255], [33256], [33261], [33262], [33263], [33264], [33265], [33266], [33267], [33269], [33270], [33271], [33273], [33340], [33361], [33362], [33363], [33364], [33365], [33366], [33390], [33391], [33404]-[33418], [33420]-[33477], [33496], [33600]-[33622], [92986], [92987], [92990], [92997], [93600]-[93656], [0345T], [0483T], [0484T], [0543T], 0544T, [0545T], ~~0569T~~, 0571T, 0572T, 0573T, [0574T], [0614T], ~~0646T~~)

(Report X678T only once per procedure session)

(Do not report X678T in conjunction with [76376], [76377])

Typical Patient (X678T)

A 79-year-old female with heart failure and left bundle branch block undergoes conduction system pacing lead implantation under fluoroscopy. 2-dimensional (2D)/3-dimensional (3D) registration of a previously acquired computed tomography angiography (CTA)-derived 3D conduction model is performed.

Revised Description of Procedure (X678T)

A previously generated CTA-derived 3-D conduction system model is imported into a fusion/navigation platform. The physician or other qualified health professional (QHP) performs 2-D/3-D registration of the model to intraprocedural imaging (eg, fluoroscopy and/or ultrasound), verifies alignment, and continuously monitors and adjusts registration accuracy throughout the procedure. The physician or other QHP generates a report documenting registration and clinical use of the registered overlay.

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Tab 68-Cat III-AI Analysis-Digitized Slides-Prostate Ca Tissue

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

The Panel accepted with modifications this request to: (1) establish code X672T to report oncologic augmentative analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded (FFPE) prostate cancer tissue; and (2) add an exclusionary parenthetical note to restrict reporting surgical pathology (ie, 88305, 88307, 88309) and digitization of slides (88363) procedures when done solely to complete the augmentative algorithmic analysis being performed.

The Panel modified this request by revising the typical patient content for code X672T by: (1) removing the term “Vesta Prostate” as a proprietary term; (2) adding the term “prostate cancer progression”; and (3) deleting the terms “testing” and “s, to determine the treatment plan”.

Category III Codes

- X672T Oncology (prostate), augmentative algorithmic analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded (FFPE) prostate cancer tissue, algorithm-derived parameters reported as prognostic of progression, including hematoxylin and eosin staining of tissue sections, and digitization of glass microscope slides, when performed

(Do not report X672T in conjunction with 88305, 88307, 88309, 88363 to report for hematoxylin and eosin staining when performed solely for augmentative algorithmic analysis of histomorphologic features of prostate cancer tissue)

Typical Patient (X672T)

A 72-year-old male has known prostate cancer with a new lung mass. His biopsy pathology reveals that he has metastatic prostate cancer. Formalin-fixed paraffin-embedded tissue is submitted for prostate cancer progression risk stratification to assess the patient’s progression risk.

Description of Procedure (X672T)

Hematoxylin and eosin stained slides are scanned and histomorphologic features are measured as discrete values using a deep learning platform. These histomorphologic features undergo computational analysis with proprietary algorithms reported as progression free survival. Results are communicated to appropriate caregivers as per the laboratory reporting protocol.

Tab 69-Cat III-Transcatheter Aortic Valve Leaflet Modification

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

The Panel accepted with modification Option B of this request to: (1) establish code X715T to report transcatheter modification of aortic valve leaflets during transcatheter valve implantation; and (2) add inclusionary parenthetical note following code X715T.

The Panel modified this request by adding a comma after “ie” in the code descriptor.

Category III Codes

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✚●X715T Transcatheter modification (ie, cut or ~~excision~~~~excise~~) of aortic valve leaflets during transcatheter valve ~~implantation~~~~replacement~~ (List separately in addition to code for primary procedure)

(Use X715T in conjunction with 33361, 33362, 33363, 33364, 33365, 33366)

Typical Patient (X715T)

An 81-year-old female with a failed bioprosthetic aortic valve presents with severe symptomatic aortic stenosis for valve-in-valve transcatheter aortic valve replacement. Pre-procedural computed tomography demonstrates low coronary ostial height and shallow sinuses of Valsalva. The patient presents for transcatheter modification of one or more bioprosthetic aortic valve leaflets immediately prior to percutaneous valve implantation. [Note: This is an add-on service. Only consider the additional work related to the leaflet modification procedure.]

Description of Procedure (X715T)

After percutaneous access, under fluoroscopic and transesophageal echocardiographic guidance, when performed, one or more aortic valve leaflets are engaged via catheter and intentionally cut or excised to reduce the risk of coronary obstruction following valve implantation. Angiographic and echocardiographic imaging, when performed, is evaluated to confirm successful leaflet modification and determine whether additional leaflet modification or coronary protection is needed prior to proceeding with valve implantation. Transcatheter valve implantation is reported separately.

Tab 70-Cat III-Transcutaneous Magnetic Stimulation

The Panel rejected this request to: (1) delete Category III code 0766T; (2) revise code 0767T and corresponding parenthetical notes; (3) revise the guidelines in the Category III section describing transcutaneous magnetic stimulation; and (4) delete and revise parenthetical notes throughout the code set.

As rationale for rejection of this request, the Panel noted that the following CPT Criteria have not been met:

General CPT Criterion:

B1: The proposed descriptor is unique, well-defined, and describes a procedure or service which is clearly identified and distinguished from existing procedures and services already in CPT.

Tab 71-Cat III-EGD-Pulsed Energy Duodenal Mucosal-Submucosal Regeneration

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tabs 71 and 72 were voted as a single Panel action.

Tab 71 was extracted from the Final Consent Agenda published 9-11-2026.

**Category III Release Date Note: The release date may be delayed by up to 10 days based on the date of the CPT Panel fall meeting.*

The Panel accepted with modification Option B of this request to: (1) establish codes X716T, X717T to report duodenal muco-submucosal regeneration; and (2) add an exclusionary parenthetical note following code X717T that restricts codes X716T, X717T with 43197, 43200, and 43235.

The Panel modified this request by revising code X717T by removing “hydro” from hydrothermal in the code descriptor.

Category III Codes

- X716T Duodenal muco-submucosal regeneration, transoral, with small intestinal enteroscopy, including fluoroscopic guidance when performed; with nonthermal pulsed field energy
- X717T with submucosal lift and thermal ablation

(Do not report X716T, X717T in conjunction with 43197, 43200, 43235)

Typical Patient (X716T)

A 56-year-old male with a 9-year history of type 2 diabetes, body mass index of 30.2 kg/m², and hemoglobin A1c of 8.6% remains inadequately controlled despite best pharmacological treatments (eg, metformin, sodium-glucose cotransporter-2 inhibitor, glucagon-like peptide-1 receptor agonist). The patient seeks a non-pharmacologic option to improve glycemic control, reduce medication burden and avoid additional weight gain, and risk of hypoglycemia associated with the initiation of insulin therapy.

Description of Procedure (X716T)

Under general anesthesia or deep sedation, with endoscopic guidance, the catheter is advanced over a guidewire positioned distal or by duodenoscope to the proximal jejunum throughout the therapy application. Fluoroscopic guidance may also be performed when needed. A flex circuit is deployed to achieve full mucosal contact using controlled insufflation and light suction, and selected electrode segments are activated to deliver precisely regulated high-voltage pulsed energy intended to induce cellular regeneration relevant to metabolic regulation. Treatment is applied sequentially across multiple duodenal segments with slight overlap to ensure complete coverage while avoiding the ampulla of Vater. Upon completion, the catheter is closed and removed under direct visualization and the upper gastrointestinal tract is reassessed.

Typical Patient (X717T)

A 54-year-old male with type 2 diabetes mellitus inadequately controlled on two oral agents, obesity (body mass index of 39), hypertension, and metabolic dysfunction-associated steatotic liver disease, who previously achieved 18% weight loss on glucagon-like peptide-1 therapy but discontinued due to cost and tolerability. Following multidisciplinary evaluation, he is referred for duodenal mucosal resurfacing to address progressive metabolic deterioration and weight regain refractory to pharmacologic management.

Description of Procedure (X717T)

The patient is placed in the standard left lateral decubitus position used for upper endoscopic procedures. General anesthesia or monitored anesthesia care is established and confirmed prior to scope insertion; the physician continuously monitors and adjusts sedation depth, airway patency, oxygenation, and vital signs throughout the procedure.

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The endoscope is inserted transorally and advanced through the oropharynx, esophagus, stomach, and pylorus into the proximal duodenum. The physician identifies and confirms the anatomical location of the Ampulla of Vater under direct endoscopic visualization. A fiducial mark is placed within 1 cm adjacent to the Ampulla using an endoscopic marking tool (ink or clip) while avoiding the Ampulla itself.

A guidewire is advanced through the working channel of the endoscope and positioned past the Treitz flexure into the jejunum under fluoroscopic guidance. The endoscope is then withdrawn, leaving the guidewire in place. The hydrothermal ablation catheter is advanced over the guidewire into the duodenum under continuous fluoroscopic tracking to the intended proximal treatment position. The endoscope is reinserted alongside the catheter into the proximal duodenum. The physician aligns the distal catheter markers with the previously placed ampullary fiducial mark under combined fluoroscopic and endoscopic visualization.

The following sequence is performed for each treatment segment across the full length of the post-papillary duodenum:

The expansion interface on the console is activated to inflate the balloon, which draws the surrounding intestinal mucosal tissue into the hollow cavity of the catheter via vacuum apposition. The physician visually confirms adequate mucosal apposition before advancing the treatment needles. The actuator on the catheter handle is engaged to advance the needles through each of the three ports into the submucosal space. Sterile saline, with or without methylene blue dye, at the physician's discretion based on endoscopic assessment of the mucosal lift, is delivered through the needles via the console pump system. The physician assesses the adequacy of the submucosal lift endoscopically, including the distribution and depth of the saline bleb, before proceeding. This mucosal lift cycle is performed twice in succession at each segment position.

Following the two completed mucosal lifts, the ablation cycle is initiated via the console. A controlled 90-second hydrothermal ablation is delivered to the apposed mucosal tissue. The physician monitors the ablation cycle and confirms delivery before deflating the balloon.

The balloon is then deflated, and the catheter is repositioned distally to the next treatment segment. The physician confirms, under direct endoscopic visualization, that the new catheter position avoids overlap with the previously ablated tissue while maintaining contiguous coverage of the treatment zone. This boundary judgment is repeated at each repositioning step throughout the procedure.

The above sequence of two sequential mucosal lift cycles followed immediately by one 90-second ablation cycle, followed by distal repositioning is repeated until the full anatomical length of the post-papillary duodenum from the ampulla to the Treitz flexure, approximately 10-20 centimeters, has been treated.

Upon completion of the final ablation cycle, the catheter is withdrawn under fluoroscopic guidance. The physician performs a complete endoscopic inspection of the treated mucosal surface. The endoscope is then withdrawn.

Tab 72-Cat III-EGD-Hydrothermal Ablation-Duodenal Mucosal Remodeling

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

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Tab 72 was extracted from the Final Consent Agenda published 9-11-2026.

Tabs 72 and 71 were voted as a single Panel action. See Tab 71 for Panel action.

Tab 73-Cat III-Anatomical Model 3D Printing-Rev 0559T-0560T

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

The Panel accepted with modifications this request to revise Category III codes 0559T and 0560T to include printing 3D molds from the patient's anatomy.

The Panel modified this request by: (1) adding the term “procedure” in the guidelines; (2) adding the term “patient-specific” to codes 0559T and 0560T; (3) deleting the term “mechanical” from code 0559T; and (4) deleting “of an anatomic structure” from codes 0559T and 0560T.

Category III Codes

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. These 3D-printed guides are cutting or drilling tools used during surgery a procedure and are 3D printed so that they precisely fit an individual patient's anatomy to guide the surgery-procedure. 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-the procedure.

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.

▲0559T Patient-specific Anatomical model or structure 3D-printed from image or anatomical data set(s); first individually prepared and processed component of an anatomic structure
Sunset: January ~~2030~~ 2032

+▲0560T each additional individually prepared and processed component ~~of an anatomic structure~~
structure (List separately in addition to code for primary procedure)
Sunset: January ~~2030~~ 2032
(Use 0560T in conjunction with 0559T)
(Do not report 0559T, 0560T in conjunction with 76376, 76377, 1030T, 1031T, 1032T, 1033T, 1034T, 1035T)

Typical Patient (0559T)

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A 7-year-old male with long segment scoliosis secondary to multiple congenital vertebral anomalies. Complex pedicle screw and posterior rod placement is necessary to improve the spinal curvature and prevent progression. A life size physical anatomic model is created to plan the surgical approach and guide pedicle screw placement. The model is used to consent the parents and as reference during surgery.

Description of Procedure (0559T)

There is an initial consultation with the requesting physician or qualified health professional to discuss the requested model. This discussion includes the clinical scenario, surgical needs and critical anatomy needed in the model. Imaging data is reviewed to determine if it is adequate to use to create an accurate model. The image data is then exported to dedicated segmentation software where the bony spine is separated from adjacent anatomy by a physician or qualified health care professional. The final segmented data of the anatomic part of the spine is exported into a computer-aided design file format where it undergoes further processing to meet technical requirements for 3D printing. A unique patient identifier is digitally imprinted on the model. The file is then sent to the 3D printer where materials and color are assigned before printing. After printing, the model is cleaned and post processed as needed.

A final consultation between the radiologist and surgeon is performed to review the anatomic relationships demonstrated in the model along with limitations encountered in model design.

The model is photographed and the image placed in the patient's electronic medical record.

Typical Patient (0560T)

A 12-month-old female with stridor and difficulty feeding and is diagnosed with a double aortic arch and complete cartilaginous rings. In addition to the printed 3-dimensional physical anatomic model of the aorta and great vessels (separately reported with 0559T), physical anatomic models of the airways are printed as a necessary additional part for demonstration of the patient-specific vascular and trachea relationship.

Description of Procedure (0560T)

The initial consultation between the requesting physician and the physician or qualified health care professional includes discussion of the patient's clinical scenario, surgical needs and critical anatomy needed in the model. Besides the initial anatomic part of the aorta (separately reported with 0559T), an additional anatomic part of the tracheal bronchial tree is requested. The additional anatomic part of the trachea and proximal central bronchi requires separate processing. The work steps include segmentation of the image data, conversion of that data to a 3D printing compatible file type, and digital processing of the anatomic part file using computer-aided design software by a physician or qualified health care professional.

The individually-created tracheal anatomic part is assembled together with the aorta on the 3D printer Build tray. Each anatomic part is color coded and then printed together as a single larger multi-content physical model, with the combined model requiring more material, printing time, cleaning and post processing steps than a single anatomic part of the aorta.

There is a final consultation with the ordering physician to review the anatomic parts of the model and limitations in model design. The model is photographed and the image placed in the patient's electronic

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medical record. There may be separately reported services in the same setting when additional anatomic parts are created to include in the model.

Tab 74-Cat III-AI-CTA Derived by Algorithmic Analysis-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 75-Cat III-Brain-Computer Interface (BCI) Unit Procedures

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

The Panel accepted with modifications on-site Option B of this request to: (1) establish a new Category III subsection and five Category III codes to report insertion (X705T, X706T), revision (X707T), removal (X708T) and replacement (X709T) of a brain-computer interface; and (2) add unconditional inclusionary and cross-reference parenthetical notes to direct users regarding intended reporting for code X706T and for reporting subdural implantation of strip electrodes (61531) and craniotomy with bone flap elevation for subdural implantation of an electrode for long-term seizure monitoring (61533).

The Panel modified this request by: (1) inserting the term “brain-computer interface” into the code descriptor for code X705T; (2) deleting the term “electrode” from code X706T; and (3) deleting the acronym “BCI” in codes X705T, X706T, X707T, and X708T.

Category III Codes

Brain-Computer Interface (Blue Heading)

Codes for brain-computer interface (X705T, X706T, X707T, X708T, X709T) are used to report services performed to record and translate brain activity to control external digital interfaces (eg, computer) and are not intended to report deep brain neurostimulation, monitoring, or treatment of seizures.

- X705T Twist drill, burr hole, craniotomy, or craniectomy, including imaging guidance, for implantation of brain-computer interface cortical electrode array with concomitant insertion of brain-computer interface unit; first array and unit
- ✚●X706T each additional array and unit (List separately in addition to code for primary procedure)
(Use X706T in conjunction with X705T)
(For subdural implantation of strip electrodes through 1 or more burr holes for long-term seizure monitoring, use 61531)
(For craniotomy with elevation of bone flap for subdural implantation of an electrode for long-term seizure monitoring, use 61533)
- X707T Revision of brain-computer interface, cortical electrode array, or unit
- X708T Removal of brain-computer interface, cortical electrode array, or unit, including cranioplasty, when performed

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- X709T Replacement of brain-computer interface, cortical electrode array, or unit, including cranioplasty, when performed

Typical Patient (X705T)

A 66-year-old male presents with a history of amyotrophic lateral sclerosis and progressive disability. He has not responded to treatments and is experiencing upper extremity motor weakness and significant impairment in activities of daily living. He is recommended as an appropriate candidate for brain-computer interface technology and referred to a neurosurgeon.

Description of Procedure (X705T)

Before surgery, a preoperative computed tomography or magnetic resonance imaging (separately reportable) scan may be taken to support intraoperative neuronavigation. Under general anesthesia, patient positioning is finalized. The patient's head is pinned in a head fixation device and the neurosurgeon establishes intraoperative neuronavigation. The incision site is marked, a final sterile prep and drape is completed, sterile navigation and surgical tools are connected, and a surgical time out is performed. The neurosurgeon reconfirms registration and makes the planned incision and then marks the craniectomy site. The surgeon drills a craniectomy and performs fit checks and additional drilling until proper fit is obtained. A durectomy may be performed, hemostasis obtained, and the patient is oriented toward the surgical robot. The neurosurgeon plans placement of the intracortical electrode array leads via imaging obtained by the surgical robot, confirms targeting within the desired regions of interest, and identifies surface targets to avoid cortical vessels. The neurosurgeon monitors the electrode array implantation during implantation or directly implants the electrode array, adjusting electrode array lead position as needed, and directing re-registration after any adjustments. Once insertions are complete, the needle cartridge is removed and no further electrocautery is used. The neurosurgeon places the dural substitute and lowers the implant into the burr hole, securing it to the skull with cranial screws tightened in a star pattern. The site may be irrigated, antibiotic powder may be applied, and a long-acting local anesthetic may be injected into the incision edges. The scalp is closed with sutures and/or staples, a bandage is applied and the head is removed from the clamp.

Typical Patient (X706T)

A 66-year-old male presents with a history of bulbar-onset amyotrophic lateral sclerosis that has caused progressive motor and speech disability. He is recommended as an appropriate candidate for the brain-computer interface (BCI) technology and referred to a neurosurgeon for consultation on multiple BCI implants.

Description of Procedure (X706T)

Before surgery, a preoperative computed tomography or magnetic resonance imaging (separately reportable) scan may be taken to support intraoperative neuronavigation. Under general anesthesia, patient positioning is finalized. The patient's head is pinned in a head fixation device and the neurosurgeon establishes intraoperative neuronavigation. The incision site is marked, a final sterile prep and drape is completed, sterile navigation and surgical tools are connected, and a surgical time out is performed. The neurosurgeon reconfirms registration and makes the planned incision and then marks the craniectomy site. The surgeon drills multiple craniectomies (the number determined by the number of BCI implants) and performs fit checks and additional drilling until proper fit is obtained. Durectomies

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may be performed, hemostasis obtained, and the patient is oriented toward the surgical robot. The neurosurgeon plans placement of the intracortical electrode array(s) leads via imaging obtained by the surgical robot, confirms targeting within the desired regions of interest, and identifies surface targets to avoid cortical vessels. The neurosurgeon monitors the electrode array implantation during implantation or directly implants the electrode array, adjusting electrode array lead position as needed, and directing re-registration after any adjustments. Once insertions are complete, the needle cartridge is removed and no further electrocautery is used. The neurosurgeon places the dural substitute and lowers the implant into the burr hole, securing it to the skull with cranial screws tightened in a star pattern. This process is repeated for each additional BCI implant. The sites may be irrigated, antibiotic powder may be applied, and a long-acting local anesthetic may be injected into the incision edges. The scalp is closed with sutures and/or staples, a bandage is applied and the head is removed from the clamp.

Typical Patient (X707T)

A 34-year-old female presents with irreversible complete tetraplegia due to a spinal cord injury that has caused severe impairment in activities of daily living. She has previously had an implantation of an electrode array and brain-computer interface (BCI) unit, which has allowed her to control computing devices without physical movement and partially restore functional mobility through neural signaling. Due to unexpected movement of the BCI unit, the neurosurgeon has recommended a revision procedure to revise the BCI unit's fixation to the skull.

Description of Procedure (X707T)

Standard neurosurgical preparation procedures are performed. The participant undergoes general anesthesia, and the surgical site is prepared and draped using sterile technique. Local anesthetic is placed in the wound edges for pain control. The previous incision site will be opened with sharp dissection. The screws holding the BCI unit in place are removed and replaced and fixation is confirmed. The surgical site is closed according to standard neurosurgical procedures.

Typical Patient (X708T)

A 34-year-old female presents with irreversible complete tetraplegia due to a spinal cord injury that has caused severe impairment in activities of daily living. She has previously had an implantation of an electrode array and brain-computer interface (BCI) unit, which has allowed her to control computing devices without physical movement and partially restore functional mobility through neural signaling. Due to an unrelated infection, the neurosurgeon has recommended a procedure to remove the BCI unit.

Description of Procedure (X708T)

Standard neurosurgical preparation procedures are performed. The participant undergoes general anesthesia, and the surgical site is prepared and draped using sterile technique. Local anesthetic is placed in the wound edges for pain control. The previous incision site will be opened with sharp dissection. The screws holding the BCI unit in place are removed, and any bony overgrowth preventing device removal may be removed with a high-speed drill. Once the BCI unit is unscrewed and lifted from the craniectomy edge, exposing electrode array threads, electrode array leads are cut above the polymer band proximal to the BCI unit and may be left behind or removed under microscope. A cranioplasty may be performed. Following the explanation, the surgical site is closed according to standard neurosurgical procedures.

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Typical Patient (X709T)

A 34-year-old female presents with irreversible complete tetraplegia due to a spinal cord injury that has caused severe impairment in activities of daily living. She has previously had an implantation of an electrode array and brain-computer interface (BCI) unit, which has allowed her to control computing devices without physical movement and partially restore functional mobility through neural signaling. Due to battery degradation with the original unit, the neurosurgeon has recommended a procedure to replace the BCI unit.

Description of Procedure (X709T)

Standard neurosurgical preparation procedures are performed. The participant undergoes general anesthesia, and the surgical site is prepared and draped using sterile technique. Local anesthetic is placed in the wound edges for pain control. The previous incision site will be opened with sharp dissection. The screws holding the BCI unit in place are removed, and any bony overgrowth preventing device removal may be removed with a high-speed drill. Once the BCI unit is unscrewed and lifted up from the craniectomy edge, exposing electrode array threads, electrode array leads may be cut above the polymer band proximal to the BCI unit and the threads are removed under microscopic visualization. Following complete explanation of the original BCI implant, hemostasis is obtained and the cortex is visualized. The neurosurgeon plans placement of the new intracortical BCI electrode array leads via imaging obtained by the surgical robot, confirms targeting within the desired regions of interest, and identifies surface targets to avoid cortical vessels. The neurosurgeon monitors the electrode array implantation during implantation, adjusting electrode array lead position as needed, and directing re-registration after any adjustments. Once insertions are complete, the needle cartridge is removed and no further electrocautery is used. The neurosurgeon places the dural substitute and lowers the implant into the burr hole, securing it to the skull with cranial screws tightened in a star pattern. The site may be irrigated, antibiotic powder may be applied, and a long-acting local anesthetic may be injected into the incision edges. The scalp is closed with sutures and/or staples, a bandage is applied and the head is removed from the clamp.

Tab 76-Cat III-Massively Parallel Confocal Microscopy

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tab 76 was extracted from the Final Consent Agenda published 9-11-2026.

The Panel accepted on-site Option E of this request to: (1) establish four Category III codes X685T, X686T, X687T, X688T for reporting intraprocedural fluorescence confocal microscopy; and (2) add three instructional parenthetical notes regarding appropriate reporting of the new codes.

Category III Codes

- X685T Intraprocedural fluorescence confocal microscopy of excised surgical specimen for evaluation of margin(s), each specimen; tissue preparation, image site selection(s), and image acquisition
- X686T image(s) interpretation

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- X687T Intraprocedural fluorescence confocal microscopy of tissue specimen to determine adequacy for pathology and/or laboratory evaluation, each specimen; tissue preparation, image site selection(s), and image acquisition(s)

- X688T image(s) interpretation

(For definition of specimen, see the Surgical Pathology guidelines)

(For multiple specimens that are assessed for specimen adequacy, X687T, X688T may be reported once for each specimen when multiple images are acquired and evaluated for each of those specimens)

(For multiple specimens that are assessed for specimen adequacy, X687T, X688T may be reported only once when multiple specimens are consolidated into one image)

Typical Patient (X685T)

A 62-year-old male presents with a history of grade 3 prostate adenocarcinoma Gleason 3+4. MRI does not show extra prostatic growth. The patient is scheduled for a nerve sparing prostatectomy with fluorescence confocal microscopy of excised tissue.

Description of Procedure (X685T)

After removal, the prostate specimen is cleaned, stained with fluorescent dye, rinsed, and dried. The physician logs into the confocal microscopy scanner, selects the appropriate settings, and enters patient details. The specimen is positioned on the scanner on the single use protected plate and checked for stability before scanning. Multiple scans are performed by repositioning the specimen to capture different surfaces based on clinical needs. Once imaging is complete, additional images of the same specimen may be requested, if needed.

Typical Patient (X686T)

A 62-year-old male presents with a history of grade 3 prostate adenocarcinoma Gleason 3+4. MRI does not show extra prostatic growth. The patient is scheduled for a nerve-sparing prostatectomy with fluorescence confocal microscopy of excised tissue.

Description of Procedure (X686T)

The physician or qualified health care professional reviews the patient's clinical information and examines the full set of confocal microscopy images per specimen. Areas of interest are annotated and snapshots recorded for documentation to confirm successful surgical removal of tumor.

Typical Patient (X687T)

A 62-year-old male presents with hematuria and malignant cells on urine cytology. To ensure adequacy of the specimen for pathology evaluation, transurethral resection of bladder tumor (TURBT) with fluorescence confocal microscopy is scheduled.

Description of Procedure (X687T)

The specimen is cleaned, stained with fluorescent dye, rinsed, and dried. The physician logs into the confocal microscopy scanner, selects the appropriate settings, and enters patient details. The specimen is

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positioned on the scanner on the single use protected plate and checked for stability before scanning. Images of the specimen is performed.

Typical Patient (X688T)

A 62-year-old male presents with hematuria and malignant cells on urine cytology. To ensure adequacy of the specimen for pathology evaluation, transurethral resection of bladder tumor (TURBT) with fluorescence confocal microscopy is scheduled.

Description of Procedure (X688T)

The physician or qualified health care professional reviews the patient's clinical information and examines the confocal microscopy images of the specimen. Areas of interest are annotated and snapshots recorded for documentation to confirm tissue adequacy sufficient for pathological diagnosis.

Tab 77-Cat III-Restoration-Remodeling-Left Ventricle

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tab 77 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted Option B of this request to: (1) establish Category III code X681T for reporting surgical left ventricular restoration procedure via plication using an epicardial ventricular anchoring system; and (2) add an exclusionary parenthetical note restricting reporting of code X681T with codes 33542, 33548, and 0643T.

- X681T Surgical left ventricular restoration procedure via plication using epicardial ventricular anchoring system, including imaging guidance

(Do not report X681T in conjunction with [33542], [33548], [0643T])

Typical Patient (X681T)

A 65-year-old male with prior anterior ST-elevation myocardial infarction presents with symptomatic heart failure and reduced ejection fraction despite optimal medical therapy. Imaging demonstrates a discrete, transmural (>50%) anterior-apical left ventricular scar with associated ventricular dilation and akinetic/dyskinetic myocardium. The patient is scheduled for surgical ventricular restoration of the left ventricle.

Description of Procedure (X681T)

A left anterolateral thoracotomy is performed and the left ventricle is exposed without cardiopulmonary bypass. Epicardial landmarks and areas of myocardial scar are identified using direct visualization and intraoperative imaging. Paired epicardial anchors connected by a tether are placed across areas of transmural scar on the left ventricular free wall. The tether is tensioned under controlled force to achieve myocardial plication, exclude nonfunctional tissue, and reduce left ventricular volume. Ventricular geometry and repair are assessed intraoperatively, and the thoracotomy is closed.

Tab 78-Cat III-Transvenous Endovascular CSF Shunt

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This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tab 78 was extracted from the Final Consent Agenda published 9-11-2026.

The Panel accepted with modification Option B of this request to: (1) establish Category III code X710T to report endovenous cerebrospinal fluid shunt creation with dural/subarachnoid cisternal transcatheter placement of shunting device; and (2) add an exclusionary parenthetical note to restrict reporting of catheter (36010, 36012) and imaging (75860, 76000, 76937, 76998) procedures.

The Panel modified this request by removing code 75893 from the exclusionary parenthetical note.

Category III Codes

- X710T Endovenous cerebrospinal fluid shunt creation, dural/subarachnoid cisternal transcatheter placement of shunting device via the inferior petrosal sinus, including venous access, ultrasound guidance for vascular access, and all associated radiological supervision and interpretation, including all catheter placement(s) and intraprocedural roadmapping and image guidance necessary to complete the shunt placement, when performed
(Do not report X710T in conjunction with 36010, 36012, 75860, 76000, 76937, 76998)

Typical Patient (X710T)

A 60-year-old male presents with normal pressure hydrocephalus, progressive gait disturbance, and cognitive decline. Magnetic resonance imaging demonstrates ventriculomegaly out of proportion to cortical atrophy and lumbar puncture trial. Endovascular placement of cerebrospinal fluid shunting is recommended.

Description of Procedure (X710T)

Prepare and drape in the usual sterile fashion. Under sterile conditions, obtain venous access using real-time ultrasound guidance and place an intravascular sheath. Advance a guide catheter over guide wire through the sheath and venous system into the jugular vein. Through the guide catheter, perform diagnostic angiographic evaluation to define the venous anatomy and confirm suitability for treatment. Subsequent procedural planning is performed with 3D rotational angiography including post-processing at an independent workstation to further characterize the access pathway, target anatomy, and spatial relationship of adjacent structures.

Having established anatomic suitability, shunt placement proceeds through the established venous access. A microcatheter is loaded through the inner lumen of the shunt delivery catheter to select through the inferior petrosal sinus distal to the intended implantation site. The microcatheter is exchanged for the implant delivery system. The shunt delivery catheter and delivery system are withdrawn to position under fluoroscopic guidance. An integrated needle in the implant delivery system is exposed, and the system is advanced through the vein wall and the dura into the cerebellar pontine angle cistern. The implant is delivered into the cistern through the lumen of the needle. The needle and implant delivery system are withdrawn into the inferior petrosal sinus. The delivery system and shunt delivery catheter are then removed deploying the remaining intravenous portion of the implant. The guiding catheter and sheath are removed and venous hemostasis at the puncture site is achieved.

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A cone beam computed tomography scan is acquired and subjected to post-processing to evaluate implant position and assess for acute procedural complications.

Tab 79-Cat III-Non-focused Hemispheric Porphyrin Metabolite Activation

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tab 79 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted Option C of this request to: (1) establish a new Category III heading, guidelines, and a Category III code X711T for reporting external hemispheric ultrasound-mediated porphyrin metabolite activation for glioma cell destruction; and (2) add a parenthetical note instruction to report supply of the self-administered sonosensitive drug separately.

Category III Codes

External Hemispheric Ultrasound-Mediated Porphyrin Metabolite Activation for Glioma Cell Destruction (Blue Heading)

~~High grade gliomas are the most common adult primary brain tumors with glioblastoma representing the most malignant. Subsequent to surgical resection combined with radiation and chemotherapy, consensus is lacking on treatment for recurrent disease. Sonodynamic therapy, is an emerging treatment option for glioblastoma; that represents the oral administration of a sonosensitive drug, such as 5-Aminolevulinic acid (5-ALA) which induces glioma cell accumulation of protoporphyrin IX, an energy-excitabile porphyrin metabolite. Upon external application of hemispheric ultrasound, the accumulated protoporphyrin IX is activated which generates generating cytotoxic reactive oxygen species that result in tumor cell destruction. In contrast to direct intraoperative ultrasound application to a localized target, X711T entails-involves the application of a helmet by which ultrasound is delivered externally to the intended hemisphere. The procedure is performed in a facility setting, and localizing imaging modalities, such as magnetic resonance imaging or computed tomography, are not used for the procedure.~~

- X711T External, non-focused, hemispheric, unilateral ultrasound-mediated porphyrin metabolite activation for glioma cell destruction, including supervision of sonosensitive agent self-administration, treatment preparation (including head shaving as needed, ultrasonic coupling gel application, coupling membrane installation), and treatment monitoring
(Report supply of self-administered sonosensitive drug separately)

Typical Patient (X711T)

A 64-year-old male with glioblastoma who previously received tumor resection followed by a 6-week chemoradiation course presents for non-focused hemispheric ultrasound-mediated porphyrin metabolite activation.

Description of Procedure (X711T)

Following patient self-administration of sonosensitive drug and monitoring in a low-light setting by clinical staff under the physician's supervision, the patient is prepared for treatment, which includes, as needed, head shaving, application of ultrasonic coupling gel to the patient's scalp, and installation of the

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single use coupling membrane with the helmet transducer. The patient is positioned in the treatment chair and raised into the treatment helmet with adjustments made to ensure proper membrane placement and continuous scalp contact. During ultrasound-mediated activation, the patient's position is periodically assessed to maintain adequate coupling. At the conclusion of the treatment, the coupling membrane is removed from the patient's scalp and clinical staff provide post-treatment observation. The supervising physician or other qualified health care professional documents a procedure note including any adverse events that occurred before, during, or after treatment.

Tab 80-Cat III-Lithotripsy w Intrarenal Pressure (IRP) Treatment-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 81-Cat III-Microwave Cold Argon Plasma Therapy

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tab 81 was extracted from the Final Consent Agenda published 9-11-2026.

The Panel accepted with modifications on-site Option C of this request to: (1) establish Category III codes X674T and X675T to report microwave cold argon plasma wound therapy; (2) add an unconditional inclusionary parenthetical note following code X675T regarding appropriate reporting.

The Panel modified the request by: (1) adding the phrase “including debridement, when performed” to code X674T; (2) deleting the instructional parenthetical note following code X675T; and (3) revising the typical patient and description of procedures for code X674T.

Category III Codes

- X674T Microwave cold argon plasma wound therapy, including debridement, when performed; first 10 sq cm or less wound surface area
- ✚●X675T each additional 10 sq cm wound surface area (List separately in addition to code for primary procedure)

(Use X675T in conjunction with X674T)

Typical Patient (X674T)

A 68-year-old female presents with a persistent diabetic foot ulcer that measures 9 cm² and has failed to respond to standard wound care treatment including offloading and moisture balanced dressing.

Description of Procedure (X674T)

~~Once~~ The wound is inspected and palpated, followed by documentation of status, classification, size, location, drainage, and depth, ~~as well as~~. Cleaning and debridement (if needed) of the wound bed is performed and hemostasis achieved; ~~the~~ the physician proceeds with treatment. The single patient sensor module is attached to the therapy device. Microwave cold argon plasma therapy is delivered by placing the torch head applicator with the sensor module 1 mm to 7 mm away from the wound bed for two

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minutes. The wound bed and surrounding tissue is assessed for clinical changes. A dressing is applied to the wound by nursing staff.

Typical Patient (X675T)

During a microwave cold argon wound therapy session, a 68-year-old female who has a persistent diabetic foot ulcer that currently measures 15 cm² has just undergone an initial treatment on the first 10 cm² of the wound. Additional treatment of the remaining wound area is performed. [Note: This is an add-on service. Only consider the additional work related to microwave cold argon plasma wound therapy for each additional wound surface area greater than 10 cm².]

Description of Procedure (X675T)

Following the initial patient treatment at the first part of the wound, the physician shall reposition the therapy device over the additional treatment area(s). Deliver microwave cold argon plasma therapy to the patient by placing the torch head applicator with the sensor module 1 mm to 7 mm away from the wound bed for two minutes. Assess the wound bed and surrounding tissue for clinical changes.

Tab 82-Cat III-AI Breast Malignancy Risk Score-Screening Mammogram Data

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

The Panel accepted Option B of this request to: (1) establish codes X628T, X629T to report augmentative breast malignancy risk score; and (2) add an inclusionary parenthetical note following code X629T.

Category III Codes

●X628T Breast malignancy risk score, 5-year prediction, derived by augmentative algorithmic analysis of a screening-mammogram dataset acquired in separate session, with automated result

✚●X629T Breast malignancy risk score, 5-year prediction, derived by augmentative algorithmic analysis of a screening-mammogram dataset acquired in same session, with automated result (List separately in addition to code for primary procedure)

(Use X629T in conjunction with 77067)

Typical Patient (X628T)

A 50-year-old asymptomatic female had a recent bilateral screening mammogram. Her qualified health care professional requests calculation of a 5-year risk of development of breast cancer determined from that mammogram dataset and placed in the patient's medical record. The risk score is considered together with clinical factors and other available patient information to guide future screening and risk-reduction recommendations.

Description of Procedure (X628T)

A previously obtained bilateral screening mammogram study dataset is input and submitted to the artificial intelligence (AI) software. The AI software analyzes the screening mammogram and outputs a percentage probability of the patient's 5-year risk for the future development of breast cancer. The 5-year

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risk score is provided to the health system electronic medical record and/or qualified health care professional (QHP). Based on the future breast cancer risk prediction output, the QHP may suggest a change in the future screening protocol and/or risk reduction strategies, such as recommendations provided by the National Comprehensive Cancer Network 2026 guidelines for breast cancer screening and diagnosis.

Typical Patient (X629T)

A 65-year-old asymptomatic female undergoing a bilateral screening mammogram has an order for a concurrent calculation of a 5-year risk of development of breast cancer determined from that mammogram data set and placed in the patient's medical record. The risk score is considered together with clinical factors and other available patient information to guide future screening and risk-reduction recommendations. [Note: This is an add-on service. Only consider the additional work related to the additional time required in addition to the base code.]

Description of Procedure (X629T)

A bilateral screening mammogram is performed. The mammographic image dataset is submitted to the artificial intelligence (AI) software. The AI software analyzes the screening mammogram and outputs a percentage probability of the patient's 5-year risk for the future development of breast cancer. The 5-year risk score is provided to the health system electronic medical record and/or other qualified healthcare professional (QHP). Based on the future breast cancer risk prediction output, the QHP may suggest a change in the future screening protocol and/or risk reduction strategies, such as recommendations provided by the National Comprehensive Cancer Network 2026 guidelines for breast cancer screening and diagnosis.

Tab 83-Cat III-Fluorescence Wound Imaging-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 84- Cat III-AI ID of ST Elevation MI (STEMI), STEMI Equivalents

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

The Panel accepted with modifications on-site Option C of this request to establish Category III add-on code X682T for reporting noninvasive identification of ST elevation myocardial infarction (STEMI), STEMI equivalents.

The Panel modified the request by: (1) revising the code descriptor: (a) changing software analysis to algorithmic analysis; (b) changing concurrent electrocardiogram (ECG) with previously performed ECG; and (c) removing interpretation and report; (2) adding an inclusionary parenthetical note allowing reporting of code X682T with codes 93000, 93005, and 93010; and (3) revising the typical patient and description of procedure.

Category III Codes

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- ✚●X682T Noninvasive identification of ST elevation myocardial infarction (STEMI), STEMI equivalents, and acute or subacute myocardial ischemia, detected by assistive algorithmic analysis of electrocardiogram previously performed for suspicion of acute coronary syndrome (List separately in addition to code for primary procedure)

(Use X682T in conjunction with 93000, 93005, 93010)

Typical Patient (X682T)

A 68-year-old male with no prior cardiac history arrives in the emergency department with symptoms of acute coronary syndrome less than 90 minutes prior to presentation and has an electrocardiogram (ECG) of “low” or “indeterminant” risk. [Note: This is an add-on code. Only include the effort work related to noninvasive identification of ST elevation myocardial infarction.]

Description of Procedure (X682T)

The algorithm is utilized in conjunction with a previously performed 12-lead resting ECG for identification of ECG patterns consistent with acute coronary syndrome. Once the algorithm provides an output for the physician or other qualified health care professional to interpret, those results are documented in the patient's medical record.

Tab 85-Cat III-Minimally Invasive Manual Sclerostomy

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Tab 85 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted Option B of this request to: (1) establish code X719T to report manual ab externo sclerostomy and trabeculostomy; and (2) add exclusionary and cross-reference parenthetical notes to provide instruction on the appropriate reporting of other services.

Category III Codes

- X719T Manual ab externo trephination of sclera (sclerostomy) and trabecular meshwork (trabeculostomy), including injection of antifibrotic agents, when performed
(Do not report X719T in conjunction with 65800, 65815, 65850, 66020, 66030, 66170, 66172, 92020, 0621T, 1012T)
(For trabeculotomy ab externo, use 65850)
(For trabeculectomy ab externo in absence of previous surgery, use 66170)
(For trabeculectomy ab externo with scarring from previous ocular surgery or trauma, including injection of antifibrotic agents, use 66172)
(For trabeculostomy ab interno by laser, use 0621T)
(For motorized sclerostomy or trabeculostomy, use 1012T)

Typical Patient (X719T)

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A 68-year-old female with mild primary open-angle glaucoma presents with elevated intraocular pressure despite recommended topical medical therapy. A minimally invasive sclerostomy via manual trephination of the sclera is performed.

Description of Procedure (X719T)

After topical anesthesia is administered, a lid speculum is placed. Using a 27-gauge needle, subconjunctival injection of local anesthetic is performed 5-6 mm posterior to the limbus. An anti-fibrotic agent is then injected into the posterior sub-Tenon space. Following a brief diffusion interval, cohesive viscoelastic is injected into the anterior chamber. The microinvasive sclerostomy trephine device is inserted through the conjunctiva approximately 1-1.5 mm posterior to the corneal limbus. The device is oriented tangentially to the sclera with an oblique posterior trajectory. The trephination is performed manually; once the trephine has penetrated through the sclera and entered the anterior chamber, the device is withdrawn. Pilocarpine may be instilled to induce miosis and reduce iris incarceration risk. The conjunctival wound is closed by low-temperature cautery if necessary.

Tab 86-Cat III-Digital Sub-bandage Pressure Monitoring System Svcs

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tab 86 was accepted as part of the Final Consent Agenda published 9-11-2026.

The Panel accepted Option B of this request to: (1) establish Category III code X676T to report application and use of a wearable digital system for continuous, real-time sub-bandage pressure monitoring; and (2) add an unconditional inclusionary parenthetical note following code X676T to report X676T in conjunction with codes 29850 and 29851.

Category III Codes

- X676T Application of wearable, continuous, digital sub-bandage pressure monitoring system, including sensor placement at multiple anatomical sites, device calibration, and real-time pressure-data acquisition to guide compression-dressing application at point of application

(Use X676T in conjunction with 29580, 29581)

Typical Patient (X676T)

A 71-year-old female with a history of chronic venous insufficiency presents with an active venous leg ulcer on the right calf with moderate serous drainage. Ankle-brachial index is 0.92, confirming arterial sufficiency. The physician has ordered application of a multi-layer compression system targeting a sub-bandage pressure of 40 mmHg at the ankle with pressure monitor upon placement.

Description of Procedure (X676T)

The flexible multi-sensor arm of the monitoring device is mounted on a fresh, disposable adhesive strip, before being positioned along the patient's lower extremity at three anatomically relevant measurement sites. Each sensor is aligned with the underlying physiological landmarks, per the device's validated placement protocol, with the adhesive strip securing the sensor position during bandage application. The

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transmitter of the monitoring device is connected to the sensor arm, powered on, and paired with the mobile application. Device calibration is confirmed on the mobile application by ensuring the patient's leg circumferences have been appropriately entered into the mobile application across all three measurement sites (to account for impacts of radius of curvature) before bandage application begins. The clinician then begins applying the multi-layer compression over the monitoring device. The mobile application displays real-time sub-bandage pressure readings at each of the three anatomical measurement sites continuously during bandage application. As each layer of the compression system is applied, the clinician observes the pressure readings on the mobile application display and adjusts bandage tension, overlap, and spiral angle in response to the real-time feedback confirming a safe and appropriate therapeutic pressure has been achieved across all three measurement sites. The patient is to leave compression bandage in place until next visit or contact clinic if the bandage loosens substantially.

Tab 87-Cat III-Intraprostatic Cancer Immunotherapy Administration

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tab 87 was extracted from the Final Consent Agenda published 9-11-2026.

The Panel accepted with modifications on-site Option D of this request to: (1) establish a Category III code X691T reporting intraprostatic, nonhormonal anti-neoplastic immunotherapy administration (2) add an instructional parenthetical note following code 96401 regarding correct use of X691T; and (3) add an inclusionary, exclusionary and instructional parenthetical notes following X691T. The Panel modified this request by: (1) adding a comma after the term “anti-neoplastic” in the parenthetical note following 96401; (2) removing the parenthesis around the ‘s’ and replacing with brackets in a parenthetical note following X691T; and (3) removing the terms “used for antineoplastic purposes provided” from a parenthetical note following X691T.

Category I Medicine

Hydration, Therapeutic, Prophylactic, Diagnostic Injections & Infusions, & Chemotherapy Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration Injection and Intravenous Infusion Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration

96401 *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic*
(For intradermal cancer immunotherapy injection, see 0708T, 0709T)
(For immunotherapy administration, intraprostatic, nonhormonal anti-neoplastic, use X691T)

Category III Codes

- X691T Immunotherapy administration, intraprostatic, nonhormonal anti-neoplastic, including all imaging guidance
(Report X691T only once per treatment episode)

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(Report X691T in conjunction with code[s] for the immunotherapeutic agent)

(Do not report X691T in conjunction with 76872, 76942)

(For subcutaneous or intramuscular chemotherapy administration, use 96401)

(For intralesional chemotherapy administration, see [96405], [96406])

(For intradermal cancer immunotherapy injection, see [0708T], [0709T])

REVISED Typical Patient (X691T)

A 69-year-old male is diagnosed with high-risk prostate cancer. ~~Therapeutic options are discussed with the patient. After informed decision making, t~~The patient elects to proceed with transperineal injection of Aglatimagene besadenovec along with external beam radiotherapy (EBRT).

REVISED Description of Procedure (X691T)

~~A time out is performed for patient identification. The patient is placed in the dorsal lithotomy position. A digital rectal examination is performed. Anesthesia is administered. A transrectal ultrasound probe is introduced into the rectum (separately reported). Real time imaging is obtained in both transverse and sagittal planes to confirm adequate visualization of the prostate. The perineal site is cleansed with povidone iodine (betadine) solution. The scrotum is retracted superiorly and secured with surgical tape to expose the perineal access site.~~

Under sterile technique, the medication is drawn up into a 5 mL syringe. Real-time imaging is obtained in both transverse and sagittal planes to confirm adequate visualization of the prostate. A spinal needle is introduced transperineally and advanced into the right mid-gland under transverse imaging with the needle tip 5-10 mm from the prostatic base. The syringe containing the therapeutic agent is attached to the spinal needle hub, and 0.5 mL of the therapeutic agent is injected. The needle is withdrawn under ultrasound visualization to a position 5–10 mm from the right prostatic apex and a second injection of the therapeutic agent is administered. The 5 mL syringe is disconnected, and the spinal needle is flushed with sterile saline to clear residual medication and deposit any remaining drug at the apical site. The spinal needle is withdrawn from the perineum, repositioned under ultrasound guidance to the transverse plane, 5–10 mm from the left prostatic base and a third injection of the therapeutic agent is administered. The needle is withdrawn under ultrasound visualization to 5–10 mm from the left prostatic apex and a fourth injection of the therapeutic agent is administered. The spinal needle is flushed with sterile saline to clear residual medication and deposit any remaining drug at the apical site.

Upon completion of all injections, the transrectal ultrasound probe is removed. A sterile 4×4 gauze dressing is applied to the perineum. Hemostasis is confirmed by brief manual pressure as needed. Vital signs are measured. The patient is transferred from the procedural table when stable.

Tab 88-Cat III-Nonendoscopic Capsule-based Esophageal Cell Collection

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

Tab 88 was accepted as part of the Final Consent Agenda published 9-11-2026.

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The Panel accepted this request to: (1) establish Category III code X692T reporting nonendoscopic esophageal cell collection for evaluation of esophageal disease; and (2) add exclusionary and inclusionary parenthetical notes regarding the appropriate use of X692T.

Category III Codes

- X692T Non-endoscopic esophageal cell collection for evaluation of esophageal disease (eg, Barrett's esophagus), using a swallowable device (eg, capsule balloon catheter or capsule sponge), including capsule-device administration, device deployment, and cell-sample retrieval

(Report X692T only once per date of service)

(Do not report X692T in conjunction with 43197, 43198, 43235, 43236, 43237, 43238, 43259, when performed on the same date of service)

Typical Patient (X692T)

A 57-year-old obese white male presents with a 10-year history of chronic gastroesophageal reflux disease, well-controlled on acid suppressive therapy is recommended to undergo screening for Barrett's esophagus.

Description of Procedure (X692T)

After appropriate consent, trained clinical staff ~~facilitates~~ educates the patient ~~swallowing of the cell collection,~~ and the patient swallows the capsule device. The attached catheters are held externally, and the patient is observed during swallowing to ensure progression of the device through the esophagus to the stomach. Once the capsule is swallowed and reaches the stomach, the cell collection device (eg, a balloon or sponge) is released. The cell-collection device is withdrawn through the esophagus. Esophageal cells are collected by circumferential contact with the mucosal surface. Collected cell samples are retrieved and packaged for transport to the reference lab for analysis.

Tab 89-Cat III-Visible-light Spectroscopy-Oxygenation Measurement-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 90-Cat III-Surgical Rehearsal w Fully Operable 3D Model

The Panel postponed until time uncertain this request to establish Category III code X683T for reporting patient-specific surgical rehearsal using a fully operable 3D model by the operating surgeon performing the definitive procedure, including image data segmentation, model fabrication and delivery to surgeon, and hands-on rehearsal.

As a rationale for postponement, the Panel instructed that the following issues be addressed:

1. Provide language that addresses use by robotic and non-robotic procedures (eg, endovascular).
2. Confirm the services that are required as part of the procedure (eg, dissection, cutting, suturing).

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3. Address who may perform this procedure.
4. Address usage and include instruction for anatomic 3D-printed modeling, see 0559T, 0560T.

Tab 91-Cat III-AI-US Algorithmic Assessment-Middle Ear Effusion-Withdrawn

This issue was withdrawn by the requestor prior to the meeting.

Tab 92-Cat III-Accelerated Repetitive Transcranial Magnetic Stimulation

The Panel rejected this request to establish four Category III codes X693T, X694T, X695T, X696T and all corresponding parenthetical notes reporting accelerated transcranial magnetic stimulation.

General CPT Criterion:

B3: The proposed descriptor for the procedure or service is neither a fragmentation of an existing procedure or service nor currently reportable as a complete service by one or more existing codes (with the exclusion of unlisted codes). However, procedures and services frequently performed together may require new or revised codes.

Tab 93-Cat III-Bronchoscopy w Drug-coated Balloon Delivery

This action will be released October 1, 2026*, effective January 1, 2027. Published in the 2028 codebook.

The Panel accepted with modifications this request to: (1) establish new Category III codes X712T, X713T to report rigid or flexible bronchoscopy for therapeutic drug delivery by drug-coated balloon catheter, including mechanical dilation for stricture/stenosis (X712T) and for additional treatment of stricture/stenosis (X713T); and (2) include exclusionary and cross-reference parenthetical notes to: (a) provide instructions regarding restrictions from reporting; and (b) direct users to the correct code(s) to report the procedure performed.

The Panel modified this request by: (1) adding the term “stricture or stenosis” to the descriptor for code X713T and removing the term “subsequent” from this code; (2) revising code X713T into an add-on code (including addition of add-on code parenthetical note language and the add-on symbol); (3) removing code X712T from the exclusionary instruction for code X713T, and code X713T from the exclusionary parenthetical note for code X712T; (4) deleting the instructions regarding use of the modifier 59 for treatment of each additional stricture/stenosis; and (5) revising the typical patient for X713T to reflect add-on language.

Category I
Surgery
Respiratory System
Trachea and Bronchi
Endoscopy

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31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)*
(Do not report 31622 in conjunction with X712T, X713T)

...

31630 *with tracheal/bronchial dilation or closed reduction of fracture*
(Do not report 31630 in conjunction with X712T, X713T)
(For bronchoscopy, rigid or flexible, with initial or subsequent mechanical dilation followed by therapeutic drug delivery by drug-coated balloon catheter, see X712T, X713T)

Category III Codes

●X712T Bronchoscopy, rigid or flexible, including fluoroscopic guidance when performed, with therapeutic drug delivery by a drug-coated balloon catheter, including mechanical dilation (eg, rigid dilator, nondrug-coated balloon) for stricture or stenosis; ~~initial~~ first stricture or stenosis

(Do not report X712T in conjunction with 31622, 31630)

✚●X713T each additional stricture or stenosis (List separately in addition to code for primary procedure)

(Use X713T in conjunction with X712T)

(Do not report X712T, X713T in conjunction with 31622, 31630)

(For bronchoscopy with dilation without therapeutic drug delivery, use 31630)

Typical Patient (X712T)

A-69-year-old female with a history of lung transplant presents with a recurrent bronchial stricture causing dyspnea and stridor. The patient undergoes bronchoscopy with mechanical dilation followed by therapeutic drug delivery by drug coated balloon catheter.

REVISED Description of Procedure (X712T)

After induction of anesthesia, a cuffed spiral endotracheal tube is properly positioned in the trachea. The bronchoscope is advanced through the endotracheal tube and beyond the trachea into the left mainstem bronchus where a 4 mm diameter distal bronchial stricture is observed. Serial dilations are performed initially starting with a 4 mm nondrug-coated balloon followed sequentially to a 10 mm nondrug-coated balloon. Once appropriately dilated, the bronchoscope is advanced beyond the stricture where the lobar and segmental bronchi appear patent. The bronchoscope is then pulled back to the dilated stricture and a 10 mm pre-hydrated drug-coated balloon catheter placed across the stricture. The drug-coated balloon is inflated to 12mm for a period of 10 minutes to ensure maximal diameter of the stenosis and adequate deposition of the antiproliferative medication into the stricture. After deflation and removal of the drug-coated balloon catheter, the bronchoscope is used to evaluate and confirm sufficient surface deposition

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across the entire stricture. The bronchoscope is removed and the patient ~~was~~is taken to the recovery room.

REVISED Typical Patient (X713T)

~~A 74 year old male with a history of a prior traumatic intubation having required standard dilations in the past presents with a recurring tracheal stricture causing dyspnea. Diagnostic bronchoscopy confirms recurrence of his tracheal stricture. The patient elects bronchoscopy with mechanical dilation followed by therapeutic drug coated balloon catheter to reduce recurrence.~~ A 69-year-old female with a history of lung transplant presents with a recurrent bronchial stricture causing dyspnea and stridor. The patient undergoes bronchoscopy with mechanical dilation followed by therapeutic drug delivery by drug-coated balloon catheter. [Note: This is an add-on code. Only consider the additional physician work related for each additional stricture treated.]

REVISED Description of Procedure (X713T)

~~After induction of anesthesia, a cuffed spiral endotracheal tube is properly positioned in the trachea. The bronchoscope is advanced through the endotracheal tube and into the right mainstem bronchus where a 6 mm diameter stricture is identified. A microknife is inserted through the bronchoscope and incisions are made at four locations in the stenosis to facilitate mechanical dilation. Serial dilations are performed initially starting with a 4 mm nondrug coated balloon followed sequentially to a 10 mm nondrug coated balloon. Once appropriately dilated, the bronchoscope is advanced beyond the stricture where the distal trachea appeared patent. The bronchoscope is then pulled back to the dilated stricture and a 12 mm pre-hydrated drug coated balloon catheter placed across the stricture. The drug coated balloon is inflated for an initial three minute period then deflated to allow reoxygenation. The balloon is then reinflated for an additional three minutes to allow maximum deposition of the antiproliferative medication into the stricture. After deflation and removal of the drug coated balloon catheter, the entire stricture is evaluated with the bronchoscope. The bronchoscope is removed and the patient is taken to the recovery room.~~

Following bronchoscopy with mechanical dilation of and therapeutic drug delivery with a drug-coated balloon to a left main bronchial stricture, the bronchoscope is pulled back and then advanced into the right mainstem bronchus where an additional stricture is identified. Serial dilations are performed initially starting with a 4 mm nondrug-coated balloon followed sequentially to a 10 mm nondrug-coated balloon. Once appropriately dilated, the bronchoscope is advanced beyond the stricture where the distal airway appears patent. The bronchoscope is then pulled back to the dilated stricture and a 12 mm pre-hydrated drug-coated balloon catheter placed across the stricture. The drug-coated balloon is inflated to 12mm for a period of 10 minutes to ensure maximal diameter of the stenosis and adequate deposition of the antiproliferative medication into the stricture. After deflation and removal of the drug-coated balloon catheter, the entire stricture is evaluated with the bronchoscope.

Tab 94-Path-Lab CCA Form Revisions

This issue was submitted by AMA staff.

The Panel accepted with modifications on-site Option D of this request to revise the Pathology/Laboratory CCA by: (1) adding a section for AI Specific Information; (2) clarifying that the

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Path/Lab CCA form is for Category I Pathology/Laboratory section (excluding PLA), Category III, and Administrative MAAA requests; (3) revising the language, “FDA approval or clearance” to “FDA market authorization”/“FDA market authorized”; (4) revising documentation instructions for FDA information; (4) removing reference to FDA-approved test serving as a Clinical Trial Assay under the Literature Requirements section of the instructions; (4) Remove Image Bundling instructions; (5) adding a section for AI Specific Information; (6) Added and revised questions in the Data Collection section; and (7) revising the Supporting Documentation section.

The Panel modified the request by: (1) replacing the term “device” with “software” under Level of Output; and (2) adding “or tests” after “device” under Sample Clinical Reports.

Please see [Attachment A](#) for approved changes.

EXECUTIVE COMMITTEE

The Executive Committee referrals were presented to the CPT Editorial Panel. The recommendations of the Executive Committee were accepted through a consent calendar and there were no extractions.

VI. ADJOURNMENT

The CPT Editorial Panel Meeting adjourned at 11:16 (Central Time) on Saturday, September 19, 2026.

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ATTACHMENT A

September 2026 Panel Meeting Minutes

Tab 94 Path-Lab CCA Revisions

Staff Note: All changes approved by the Panel are shaded in gray.

CPT Code Change Application

Pathology/Laboratory (Including MoPath/GSP/MAAA)

American Medical Association | Current Procedural Terminology (CPT®)

Note: The test(s) for which a CPT code(s) is being requested in this code change application must be available for patient care at the time of application submission.

Pathology/Laboratory Code Change Application (CCA)

The Pathology/Laboratory CCA is for requests for new content and/or changes to existing content in the code set that encompass or contain procedures and services that are provided or associated with the clinical or anatomic pathology laboratory. This form should be used for Category I Pathology/Laboratory section (excluding PLA), Category III, and Administrative MAAA requests. Category I includes services and procedures that are consistent with contemporary medical practice and are widely performed. Category III includes temporary codes related to emerging technology, services and procedures.

This Pathology and Laboratory code application requires the following documentation, if appropriate:

1. Information about the test procedure

FDA Information

FDA market authorization is not necessary for assignment of CPT code for laboratory tests and services. However, understanding the FDA status of a test or procedure is important for Panel consideration in that FDA approval for marketing affirms that the laboratory test is safe and effective for specific indications, and that the test is available for implementation by clinical laboratories.

a. FDA Approval

1. Does the procedure/service involve the use of a test or device that requires market authorization from the Food and Drug Administration (FDA)?

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2. If market authorization is necessary, have all devices and test kits necessary for performance of the procedure or service received FDA market authorization?

3. Please provide documentation of FDA market authorization, including approved authorized indications for use.

4. Please provide the FDA-authorized package insert.

b. Other FDA Status

1. Does the test or device have any other FDA designated status that is relevant to this application?

c. Laboratory Developed Tests and Procedures

1. For tests and procedures which have been validated in a CLIA certified laboratory, please identify a clinical laboratory that performs this test and the Laboratory Medical Director.

2. Understanding the technical details of a laboratory test is essential for the development of an accurate descriptor and for code placement. Please provide a copy of the most recent SOP signed by the Laboratory Medical Director, or designee, for the test under consideration. Proprietary information may be redacted but sufficient methodologic information should be retained to allow for proper descriptor development.

Add mechanism to upload SOP (Smart App team will address)

a. Other Agencies

Submission of approval documentation of tests by state or other non-FDA agencies is encouraged.

a.—For FDA-approved market authorized or cleared tests:

- 1.—A copy of the manufacturer's product insert that accompanies the test(s)
- 2.—FDA Summary of Safety and Effectiveness Data (SSED)

b.—For non-FDA approved or cleared laboratory developed tests (LDTs):

- 1.—A copy of a standard operating procedure (SOP), written in CLSI or similar from a licensed, accredited, or certified clinical laboratory that currently employs the test.
- 2.—A copy of the approval letter from a CLIA deemed agency (eg, NYS DOH GLEP); for tests that have not been reviewed and approved by a CLIA

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deemed agency, a letter from the CLIA Laboratory Director affirming that the test has been adequately validated for clinical use and a brief summary of the validation studies performed

2. Sample reports of all possible outcomes (negative, positive, etc.), with personal information redacted
3. Published guidelines on clinical usage (eg, National Comprehensive Cancer Network [NCCN] clinical guidelines, GeneReviews®, medical specialty societies), if available

Required Literature:

- ~~1. If the test is FDA-approved and served as a Clinical Trial Assay (CTA), then associated publications that relate to the test's clinical validity should be included with the application.~~
1. At least three, and no more than five, peer-reviewed articles related to the test analyte's clinical validity.
 - a. At least one reference should address the disease association of the test.
 - b. If the test method has not been previously associated with the analyte(s), then at last one reference should address the analytical performance characteristics of the test method relevant to the specific analyte(s) tested.
2. You will be asked to upload the corresponding literature.

Choose Your Role...

Application Submission Requirements

All CPT Code Change applications are reviewed and evaluated by AMA staff, the CPT/HCPAC Advisory Committee, and the CPT Editorial Panel. Applications for Category I, Category III, and Administrative MAAA laboratory analyses are also reviewed by the Pathology Coding Caucus (PCC).

Applications for the Category I and Category III Molecular Pathology, Genomic Sequencing Procedures, and Category I and Administrative Multianalyte Assays with Algorithmic Analyses subsections of the CPT code set are reviewed by the Molecular Pathology Advisory Group (MPAG) in addition to the aforementioned parties.

Strict conformance with the following is required for review of a code change application:

- Submission of a complete application, including all necessary supporting documents;
- Adherence to all posted deadlines;

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- Cooperation with requests from AMA staff and/or Editorial Panel members for clarification and information; and
 - Compliance with CPT Statement on Lobbying.
-

General CPT Code Criteria

All code change applications must satisfy each of the following criteria:

- The proposed descriptor is unique, well-defined, and describes a procedure or service which is clearly identified and distinguished from existing procedures and services already in CPT;
 - The descriptor structure, guidelines and instructions are consistent with current Editorial Panel standards for maintenance of the code set;
 - The proposed descriptor for the procedure or service is neither a fragmentation of an existing procedure or service nor currently reportable as a complete service by one or more existing codes (with the exclusion of unlisted codes). However, procedures and services frequently performed together may require new or revised codes;
 - The structure and content of the proposed code descriptor accurately reflects the procedure or service as typically performed. If always or frequently performed with one or more other procedures or services, the descriptor structure and content will reflect the typical combination or complete procedure or service;
 - The descriptor for the procedure or service is not proposed as a means to report extraordinary circumstances related to the performance of a procedure or service already described in the CPT code set; and
 - The procedure or service satisfies the category-specific criteria set forth below.
-

Category Specific Requirements

Category I Criteria

A proposal for a new or revised Category I code (including Category I MAAA) must satisfy all of the following criteria:

- 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;

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- The procedure or service is performed with frequency consistent with the intended clinical use (i.e., 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.

Parameters Specific for Category I Requirements for Molecular Pathology:

The following criteria are used by the CPT/HCPAC Advisory Committee and the CPT Editorial Panel for evaluating Molecular Pathology applications for consistent application of Category I Criteria:

- In the case of Mendelian and somatic disorders, there is a demonstrated relationship between biomarker and phenotype (i.e., clinical validity)
- Biomarkers (e.g., SNPs) that have an association but not a proven causative effect to a known clinical phenotype(s) should have demonstrated clinical usefulness (e.g., high positive predictive value, high negative predictive value, directing therapy/management).
- The analysis involves ≥ 10 variants identified in unrelated families. Multiple reports of the same variant may be included.
- For duplication/deletion (dup/del) assessment for code assignment, the following guidelines will be used:

$\geq 10\%$ of variants should have been associated with dup/del in a recognized database (eg, GeneReviews®, BIOBASE Human Gene Mutation Database [HGMD®] Professional, ClinVar).

Category III Criteria

The following criteria are used by the CPT/HCPAC Advisory Committee and the CPT Editorial Panel for evaluating Category III code applications:

- The procedure or service is currently or recently performed in humans; **AND**

At least one of the following additional criteria has been met:

- The application is supported by at least one CPT or HCPAC advisor representing practitioners who would use this procedure or service; **OR**
- The actual or potential clinical efficacy of the specific procedure or service is supported by peer reviewed literature which is available in English for examination by the Editorial Panel; **OR**
- There is a) at least one Institutional Review Board approved protocol of a study of the procedure or service being performed, b) a description of a current and ongoing United

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States trial outlining the efficacy of the procedure or service, or c) other evidence of evolving clinical utilization.

Administrative Multianalyte Assays with Algorithmic Analyses (MAAA)

The minimum standard for inclusion in this list is that an analysis is available for patient care.

Notice of Potential Review by Interested Parties...

CPT Confidentiality Agreement...

Copyright Assignment...

Statement of Compliance with the CPT Conflict of Interest Policy...

Attestations...

Rationale/Code Descriptor

Rationale for code change

Indicate the specific reasons why this code addition or change is necessary (rationale). Be specific about the reasons for this new test or test change application and avoid answering "no code is available" or "need new code" as these responses are not informative. Describe why the test is different, if appropriate, in terms of the analyte evaluated and the methodology employed.

- ☐ Freeform textbox [one textbox for entire ballot, not per code]

A screenshot of a web-based freeform textbox. It features a standard toolbar at the top with icons for bold, italic, underline, text color, background color, bulleted list, numbered list, link, unlink, and other text formatting options. Below the toolbar is a large, empty rectangular text area for input.

Code Placement

If this is a request for a new or revised code, what code placement is being suggested?

Additional guidance for code placement can be found [here](#)

[Check all that apply, for all codes (not each)]

- Category I Codes [not a checkbox]:
 - ☐ Molecular Pathology
 - ☐ GSP or other Molecular Multianalyte Assay
 - ☐ Category I MAAA

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- Other Pathology/Laboratory (specify subsection [eg, Chemistry, Microbiology])
 - [If selected, list applicable area via textbox provided]
- Administrative MAAA
- Category III

Proposed Code Changes

Please specify the proposed additions, modifications, and/or deletions to CPT Content for this Code Change Application. Begin by identifying where in the CPT Code Set your suggested changes need to be made.

- Using the “Search” feature below, you can locate any existing content in the CPT Professional book (including codes, guidelines, key words, etc.). Simply type a code, key word, or sentence in the search bar to find the existing content.
- If you aren’t sure where to place your proposed change(s), the “Table of Contents” allows you to drill into the code set by expanding sections and subsections in the CPT Professional book to locate CPT codes and guidelines.

Use both the search and drill down tools to verify that there are no codes to use for a particular procedure prior to proposing a code change. There may be codes located in a section that you are not familiar with. Also, please consider, to the degree possible, all sections of CPT that may be affected when making changes in a particular area and list the complete family of codes related to your request. This will allow the CPT Advisory Committee and Editorial Panel to perform a full review on the impact of your request on related codes.

Image Bundling: If you are recommending a code for a new base procedure or revision to an existing base procedure that is reported with imaging guidance, please consult the following Image Bundling Decision Tree to determine the correct code language structure.

Artificial Intelligence: If you are recommending a code for a new base procedure or revision to an existing base procedure which describes work associated with the use of AI-enabled medical services and/or procedures, please consult Appendix S - [Artificial Intelligence Taxonomy](#) to determine the correct code language structure.

Click [here](#) to view the Ballot Building Guide

Please note that adding or deleting any codes in this Proposed Code Changes question after you’ve responded to any of the subsequent questions in the application will require you to click Next through each question in the application again so that you can verify that all of your responses are still applicable.

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Ballot field:

AI Specific Information

Identifying Software as AI

Consistent with the Artificial Intelligence concepts addressed in Appendix S, is this a request for a service or procedure that relies on output from software which has performed more than data processing (data processing includes helping to aggregate, organize/arrange, transmit, develop, or otherwise visually enhance the data)? Refer to Appendix S for further clarification of this issue.

- Yes [Displays additional questions in section]
- No [Hides remaining questions in section]

Flow of Data

Can you provide a description of data, from input to output (PDF or Word file), such as a flow chart or step-by-step narrative, noting the following:

- The point(s) where the software acts, and the nature of the action.
- Quality check of input (separately from data acquisition, preparation, & transmission), if any
- Specify reporting mechanism and content of the output.

- Yes [Required file uploader]

File Uploader:
Drag and Drop Files Here:

FILE DROP ZONE

OR Choose Files No file chosen

- No [Required textbox]

Please explain

Level of Output

Does the proposed NEW or REVISED code describe the software output in relationship to the work performed by the physician or other QHP as assistive, augmentative, or autonomous?

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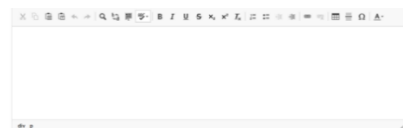
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(Note for augmentative or autonomous, clinical meaningfulness may be established in part by evidence linking the output from this software to evidence for a service or procedure in current clinical use. Refer to Appendix S for criteria.)

[For each code, required to answer “Assistive”, “Augmentative”, “Autonomous”, or “N/A”]

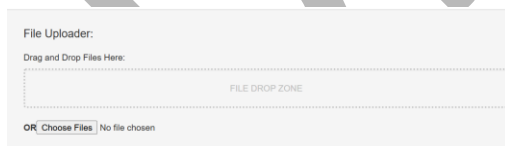
Please provide a rationale for your choice of assistive, augmentative, or autonomous for this code. Rationale should be based on the relationship of the software output to the work performed by the physician, for the service or procedure. The rationale is best supported by evidence for validation of the output. Please be specific. If “N/A” was chosen, please explain.]



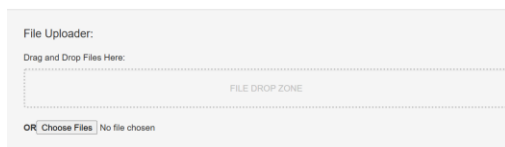
Relevant Documentation

If FDA market authorized, please provide documentation such as the FDA approval letter, FDA Summary of Safety and Effectiveness (SSED), De Novo Decision Summary and classification order, etc. If pending FDA market authorization, please provide other relevant documentation of the proposed indication for use (IFU), e.g., Breakthrough Designation Determination (BDD), Investigational Device Exemption (IDE), Research Use Only (RUO), Investigational Use Only (IUO), etc. Documentation of participation in special programs such as Regulatory Alignment for Predictable and Immediate Device (RAPID) or Technology-Enabled Meaningful Patient Outcomes (TEMPO) should also be mentioned. These will be used to evaluate the descriptor, description of procedure, typical patient, etc., and to determine the relevance of any published evidence or ongoing clinical trials. Any documentation which is provided in the “Supporting Documentation” section may be cross-referenced here by indicating the relevant text in those documents.)

- Yes, market authorized (Submit a copy of the FDA letter and documentation of the Indications for Use and Instructions for Use or Package Insert [Required file uploader]



- No, pending market authorization (Submit a copy of relevant FDA documentation of the planned Indications for Use and Instructions for Use. [Required file uploader]



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Staff Note: AMA staff have asked the Panel Reviewers if the language in yellow below is needed and are awaiting a response.

- No. FDA market authorization not pursued (Provide rationale for why FDA authorization is not required and submit a copy of relevant documentation analogous to Indications for use and Instructions for Use (may be satisfied by the Standard Operating Procedure or Package Insert; see also Supporting Documentation)). [Required textbox].
- Please refer to sections of the SOP that address the analytical and clinical validity of the AI portion of the test: How do you address the safety and effectiveness of the AI portion of the test?



Generalizability

Please describe efforts to ensure broadest generalizability of this software, e.g. curation of training databases, plans for surveillance of real-world data, etc.. (give references).

Note: Response to this question should be reflected also in the “Typical Patient” section.

[One answer, via textbox, for any/all codes in the ballot]



Social Bias

Characterize the potential for perpetuation, propagation, or mitigation of social bias, which might reasonably be anticipated (give references).

[One answer, via textbox, for any/all codes in the ballot]



Data Collection

Clinical Trials

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Please identify and summarize any proposed or ongoing clinical trials related to the service(s) or procedure(s). Indicate N/A if not applicable. Be sure to include links to <https://clinicaltrials.gov/>.

[One answer, via textbox, for any/all codes in the ballot]



If no clinical trials, are there any precedent assays used in clinical trials? Explain.



Tests Performed Annually

☐ Please specify the volume of test(s) performed annually.

☐ [Freeform box that allows only numbers:]



☐ [For all codes in the entire ballot, not for each code]

☐ Volume (select (only) one [via dropdown menu])

☐ <50

☐ 50-99

☐ 100-499

☐ 500-999

☐ 1,000-9,999

☐ 10,000-99,999

☐ > 100,000

☐ Explain [via textbox]

☐ Please provide source of data, and/or rationale for the estimate of the volume provided.

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Tests performed in Laboratories

Is this test(s) you are proposing performed by multiple laboratories (e.g. reference laboratories, hospital laboratories, physician office laboratories)?

[For all codes in the entire ballot, not for each code]

☐ Yes

- [If selected] Please indicate the number of laboratories performing the test(s).
[(select (only) one via freeform box dropdown menu)]

Please provide source of data, and/or rationale for the estimate of the volume provided.

- ☐ <5
- ☐ 5-10
- ☐ 11-20
- ☐ 21-49
- ☐ 50-99
- ☐ 100-499
- ☐ 500-999
- ☐ 1,000-9,999
- ☐ 10,000-99,999
- ☐ > 100,000

☐ No [No additional action-If selected, explain via textbox provided]

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Please explain



Do you anticipate this number to change in the future? If so, why? (NOTE: anticipated volume increase in itself is an insufficient reason to support issuance of a new CPT code. However, sound, evolving clinical practices will be considered by the CPT Editorial Panel)
[response via textbox]



Distinct Service

Is the suggested procedure/service a distinct service ordered by many clinicians across the United States, with frequency consistent with the intended clinical use (i.e., a service for a common condition should have high volume, whereas a service commonly performed for a rare condition may have low volume)? Please explain.

[For each code, choose (only) one of the following]

- ☐ Yes [If selected, explain via textbox provided]



- ☐ No [If selected, explain via textbox provided]

Please explain.



☐

Current Code Justification

Please indicate which CPT code(s) or HCPCS Level II code(s) are currently being used to report the proposed test(s). Indicate if either a less specific code or unlisted code is currently being used to code for this service.

- ☐ [For each code, one or more code(s) and rationale(s) listed]

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Present Codes Inadequate

A new code may be required whenever the existing test or service has been updated in a manner that materially alters the original code descriptor, clinical indications, performance claims, or result reporting. Examples of changes that may trigger the need for a new code include:

1. Additional nucleic acid (DNA or RNA) and/or protein analysis(es) are added to or removed from the current test.
2. The algorithm (if used) has been materially changed so that it has expanded beyond its original intent, and

The addition or modification of the therapeutic applications of the test requires the submission of a code change application, but it may not require a new code number.

Why is (are) the present codes (noted in the "Current Code Justification" question) inadequate to describe the test, and how will specificity created by this code change improve reporting and test identification?

- Freeform textbox [one textbox for entire ballot, not per code]

If a test represents a variation in a testing methodology or a new analyte employing an existing methodology, do the existing codes describe the test but not to the same level of specificity?

- Freeform textbox [one textbox for entire ballot, not per code]

How will specificity created by this code change improve reporting and test identification?:

- Freeform textbox [one textbox for entire ballot, not per code]

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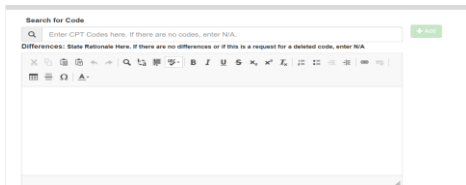
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Major Code Differences

Identify the major differences between the proposed code change and any other related codes already existing in CPT. When the procedure described in the proposed code is similar to that of an existing code, please give a detailed explanation of the differences (eg, testing methodologies, associated diseases).

- [For each code, one or more code(s) and difference(s) listed]

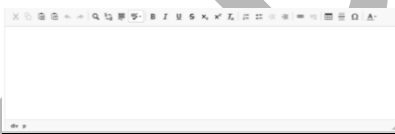


Concurrent CCA Submissions

Has a code change request been submitted for this same test(s) in another section of CPT (e.g., PLA) concurrently with this application?

- Yes [If selected, explain via textbox for entire ballot, not per code]

Please explain.

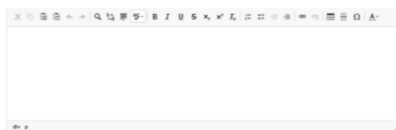


- No [no additional action]

Integral Codes

Are there any codes, existing or proposed, including PLA codes, that are an integral part of the proposed code? This list should include CPT codes for all tests that, if coded in addition to the code(s) for this test(s), would represent unbundling or double billing.

- [For each code, list integral code(s) via textbox]



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Performance or Quality Measure by any National Organization

Is the test for which you are proposing a code change used as a performance or quality measure by any national organization (eg, evaluation of clopidogrel metabolism in a patient with history of acute MI)? If yes, specify the organization and name of the measure.

[For all codes in the entire ballot, not per code]

- ☐ Yes [If selected, provide Organization and Measure name via textboxes]

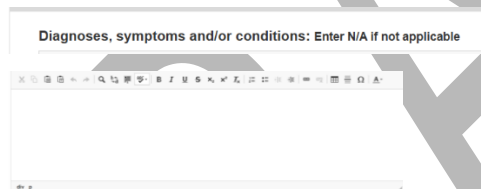
A screenshot of a web form showing a large, empty text input area with a standard toolbar at the top, intended for entering the organization and measure name.

- ☐ No [no additional action]
- ☐ Don't Know [no additional action]

Diagnosis/Condition for Treatment

What are the diagnoses, symptoms and/or conditions that the test seeks to diagnose or follow?

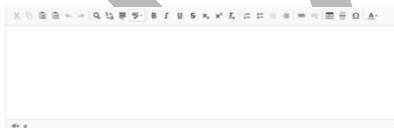
- ☐ [For each code, list diagnoses, symptoms and/or conditions via textbox]

A screenshot of a web form with a title bar that reads "Diagnoses, symptoms and/or conditions: Enter N/A if not applicable". Below the title bar is a large, empty text input area with a toolbar.

Prevalence of Diagnoses

What are the incidences or prevalence of the diagnoses, symptoms and/or conditions that the test seeks to diagnose or follow?

- ☐ Freeform textbox [one textbox for entire ballot, not per code]

A screenshot of a web form showing a large, empty text input area with a standard toolbar at the top, intended for freeform text entry.

Analyte/Biomarker-Disease Association

Has the analyte/biomarker-disease association been established? Please provide up to three relevant citations. Articles generally discussing the disease or disease pathophysiology do not satisfy this requirement.

[For all codes in the entire ballot, not per code]

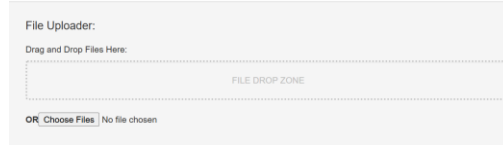
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- Yes [If selected, required file upload]

- Please highlight the applicable section of the articles discussing the biomarker-disease association, if not readily apparent (e.g., included in the title), and upload the article with the applicable portions highlighted.



- Please provide a concise relevance statement.

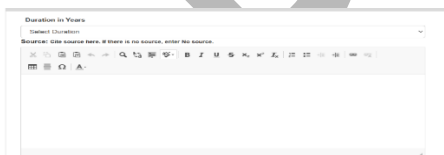


- No [no additional action]

Years of Procedure Being Performed

How long (e.g., years) has the test been offered to patients? This information can be obtained from the medical literature (preferably United States peer-reviewed literature), funded studies (please indicate whether these studies are funded by the manufacturer, the government, or another agency). Literature can be cited in bibliographical format. For the CPT Editorial Panel to add a Category I code, the documentation must substantiate that the test(s) are widely used and accepted.

- [For each code, enter the following]
- Duration in Years (select (only) one [via dropdown menu])
 - <1, 2, 3, 4.....10, 10+
- Source [via textbox]



Clinical Laboratory Improvement Amendment

How is this test classified under CLIA?

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[For each code, choose (only) one of the following]

- ☐ High complexity
- ☐ Moderate complexity
- ☐ Waived

Estimated Percentage Usage

If you are recommending a new code, please estimate the percentage of the testing currently performed using existing codes that would now be coded using the proposed new code(s).

[For each code, one or more code(s)]

Now reported as

(Enter Codes Here. If there are no codes, enter N/A. [dropdown box])

Percentage

(Enter Percentage. [text box])

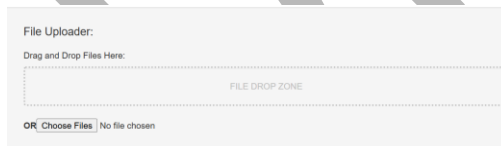


Practice Guidelines

Are you aware of any published guidelines regarding clinical usage of this test (eg, National Comprehensive Cancer Network [NCCN] clinical guidelines, GeneReviews®, medical specialty society policy statements)? If yes, please provide copies.

[For each code, choose (only) one of the following]

- ☐ Yes [If selected, required file upload]



- ☐ No [No additional action]
- ☐ Don't Know [No additional action]

Proprietary Test Interest (for Category I and Administrative MAAA tests only)

Are you a proprietor, manufacturer, or performing laboratory?

[For all codes in the entire ballot, not per code]

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- Yes
- No

Identify other stakeholders who have an interest in this test.

- [Optional additional details]
- Name [via textbox]
- Address(es) [via textbox]
- Email address(es) [via textbox]

Contacting Laboratory

Please list all the specialty societies and relevant stakeholders that you have notified about this CCA.

Have you contacted *all* the relevant stakeholders (i.e. performing laboratory(ies) and test proprietor) of the procedure represented in this proposal? (answer required only if requesting a Category I MAAA code or Administrative MAAA code)?

[For each code, choose (only) one of the following]

☒ Yes

- ~~[If selected]~~ If yes, Please describe the interaction and disclose whether or not the stakeholder(s) supports the code change request



☐ No [No additional action]

☐ N/A [No additional action]

Physician Services

Performing Specialties

Of the CPT and or Health Care Professional Advisory Committee specialties listed in CPT, please identify the specialties or subspecialties that might be impacted by the test(s) proposed, either because they might perform the test or use the results.

- [For each code, enter specialty via textbox]

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Site of Service

What is the typical site of service where this test is performed?

- [For each code, choose one or more of the following]
- Independent Laboratory
- Physician's Office Laboratory
- Hospital Laboratory
- Emergency Medical Transport Facility
- Home Health Service Laboratory
- Other
 - [If selected, explain via textbox provided (required)]



Vignette-typical patient/description of procedure

Clinical Vignette/Typical Patient

Provide a clinical vignette that describes the typical patient that would receive this test. The vignette should include any special specimen collection and storage needs, analytic requirements, or reporting requirements.

Example: A 72-year-old man has a PSA of 4.5 ng/mL. His biopsy pathology reveals that he has 2 of 12 positive cores and his Gleason score is 6 for both cores. His stage is T1c, no masses were felt on digital rectal exam. The Prolaris test is ordered to inform an appropriate intervention (radical prostatectomy, radiation therapy or active surveillance).

Example: A 20-year-old female presents with a brain tumor that cannot be histologically classified. Tissue is submitted to better define the tumor type using the DNA methylation classifier.

Example: A 75-year-old male, who is from a nursing home facility, is admitted with a fever and buttock cellulitis associated with a decubitus ulcer. A blood culture yielded a gram-negative bacillus. Gene testing for carbapenem-resistance is ordered.

Example for an add-on code: During partial mastectomy (eg, lumpectomy), a 65-year-old female who is undergoing breast conserving surgery to remove the cancerous lesion in her breast requires an additional procedure in which her ex-vivo evaluation of the lumpectomy specimen is evaluated using radiofrequency spectroscopy to assess the surgical margins for microscopic disease during

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surgery. Note: This is an add-on service. Only consider the additional work related to surgeon comprehensive assessment of the cancerous specimen using radiofrequency spectroscopy. A 48-year-old female's ventral hernia specimen is examined. Glass microscope slide digitization is performed. [Note: This is an add-on code. Only consider the additional work related to 0751T glass microscope slide digitization.]

[For each code, provide response via required textbox]

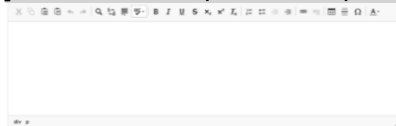
Clinical Vignette: Enter Clinical Vignette here. Do not exceed 75 words. If this is a request for a deleted code, enter N/A.



Does the proposed typical patient align with the study populations in the literature submitted with this application?

- ☐ Yes
☐ No. Explain.

[For each code, provide response via required textbox]



Description of Procedure

For each proposed NEW and/or REVISED code(s), provide a brief description of the procedure/service performed. It is important that the description of the service make apparent the services that are integral or separately reported. If the description includes services that are reported separately, please clearly indicate this separate reporting.

Example: Perform tumor methylation analysis on DNA extracted from the tumor tissue. Process the DNA methylation profiling data based on the tumor classifier and generate a classification score that indicates a probability of a match to one of the tumor classes of the central nervous system. Generate and submit a report to the ordering provider.

Example: Pure bacterial isolate undergoes bacterial DNA extraction and purification, followed by polymerase chain reaction for target amplification and detection. Report the carbapenem-resistance gene test results.

Example for an add-on code: Scan glass microscope slides using a digital slide imaging system and store the images.

[For each code, provide response via required textbox]

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Description: Enter Description of Procedure here. If this is a request for a deleted code, enter N/A.



Does the proposed description of procedure align with the procedure in the literature submitted with this application?

☐ **Yes**

☐ **No. Explain.**

[For each code, provide response via required textbox]



Supporting Documentation

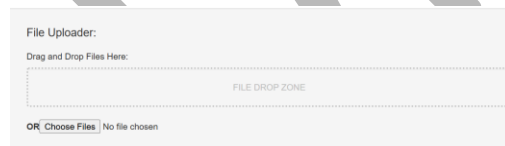
Copy of Manufacturer's Product Insert

This step is only required for applications for FDA market authorized -approved or FDA-cleared tests. Please forward upload the following documentation with your application, if appropriate. If not appropriate, please indicate why.

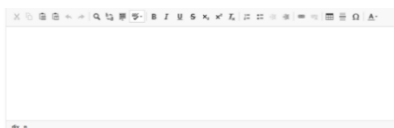
[Potential drop down list of FDA market authorizations (PMA approval, 510(k) clearance, De novo granted, HDE approval, BLA approval)]

[For all codes in the entire ballot, not per code]

- ☐ **Yes (Submit Upload a copy of the manufacturer's product insert that accompanies the test(s)) [If selected, required file upload]**



- ☐ **No This is not an FDA-approved for FDA-cleared test(s) [If selected, indicate why via required textbox]**



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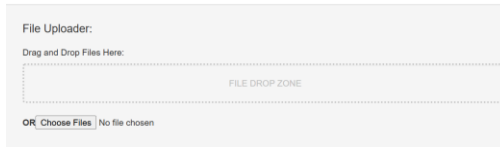
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FDA Summary of Safety and Effectiveness (SSED)

This step is only required for applications for FDA-approved, authorized or FDA-cleared tests. Please forward upload the following documentation with your application, if appropriate. If not appropriate, please indicate why.

[For all codes in the entire ballot, not per code]

- ☐ **Yes (Submit Upload** a copy of the FDA SSED) [If selected, required file upload]



- ☐ **No This is not an FDA-authorized test(s)** [If selected, indicate why via required textbox]

Please indicate why



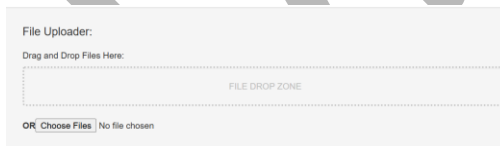
Standard Operating Procedure (SOP)

This step is only required for applications for laboratory-developed tests (LDTs) that are not FDA approved. Please forward the following documentation with your application, if appropriate.

Please include a copy of an SOP written in CLSI or similar format from a licensed, accredited, or certified clinical laboratory currently performing the test. The SOP must include sufficient technical detail to support development of an appropriate CPT code descriptor for the test.

[For all codes in the entire ballot, not per code]

- ☐ **Yes** [If selected, required file upload]



- ☐ **No** [No additional action]

Intended Use, Principle, Limitations

If not addressed in the SOP or product insert submitted for this test, please answer the following questions. If the requested information is addressed, please enter “Addressed in SOP” or “Addressed in product insert”, as appropriate.

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[For all codes in the entire ballot, not per code]

Describe the intended use of the test: [Provide response via required textbox]



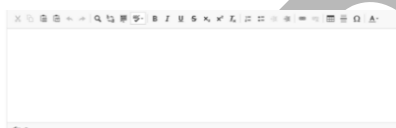
Describe the principle behind the test: [Provide response via required textbox]



Describe distinct components of the service (eg, specimen processing, laboratory analysis, digitization, computation, algorithmic evaluation, interpretation, etc.). Indicate whether any of these components are proprietary. [Provide response via required textbox]



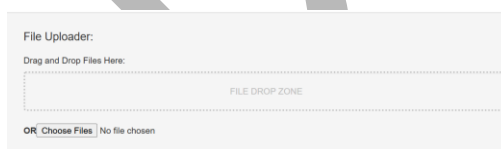
Are there any test limitations? [Provide response via required textbox]



Sample Clinical Reports

For devices or tests which utilize algorithmic analyses, please upload redacted examples of the algorithmic output as distinct from the clinical laboratory test report.

- ☐ Yes [If selected, required file upload]



- ☐ No [If selected, indicate why via required textbox]

Please explain.

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- N/A [No additional action]

Please forward upload redacted (ie, personal information) sample clinical laboratory test reports (not instrument printouts) of all possible outcomes of the test(s) (eg, positive, negative, etc.) with your application, including reference ranges, confidence scores, etc. and any physician interpretation, if appropriate. If not appropriate, please indicate why.

[For all codes in the entire ballot, not per code]

- Yes [If selected, required file upload]

- No [If selected, indicate why via required textbox]

Please explain.

- N/A [No additional action]

U.S. Versus Foreign Population

Were as any of the study(ies) submitted with your application performed on foreign populations? If yes, are the results of the study(ies) applicable to populations in the U.S. population? If yes, please provide documentation to substantiate that the results of the study(ies) are relevant to the U.S. population.

[For all codes in the entire ballot, not per code]

- Yes [If selected, required file upload]

- No [No additional action]

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Reference Citations

The literature requirements set forth below define the minimum requirements for CPT Editorial Panel (“Panel”) consideration of the application. The Panel members review the literature provided and each member makes an independent evaluation of whether the literature submitted with the application satisfies the criteria for a code change. Applicants are urged to submit the strongest literature that supports the application. **IMPORTANT:** Meeting the minimum literature requirements does not guarantee that the Panel will determine clinical efficacy of the procedure or service has been adequately demonstrated in the submitted literature. The merit of the application is based on the totality of the information in the application and other relevant information brought to the attention of the Panel. The literature requirements apply to applications that seek addition of a new procedure/service, or a new use for an existing code(s). Applicants who seek an editorial change (i.e., application seeks only editorial revision of the existing code or a clarification of use), with no change to the intended use of the code or related instructions are not obligated to meet the literature requirements. The Panel members will review suggested revision and each member makes an independent evaluation of whether the request satisfies the criteria for “editorial change only” applications.

Please provide electronic (PDF or Word documents) copy(ies) (and internet addresses, if available) of literature to support your application:

1. Provide a concise “relevance statement”.
2. ~~If the test is FDA market authorized -approved and served as a Clinical Trial Assay (CTA),~~ then any associated publications that attest to the test’s clinical validity and utility should be included with the application. Any publications which report the evidence provided to the FDA in support of authorization for distribution should be identified as such.
3. At least three, and no more than five peer-reviewed articles related to the test analyte’s clinical validity and utility. At least one reference should address the disease association of the test. Do not include references that describe the underlying disease or diagnostic condition for which the test is ordered. Different authors are preferred (i.e., no overlapping authors with the same patient population among the articles submitted). Articles submitted with the designation of “Confidential” will not be accepted nor included in the supporting literature reviewed by the CPT Editorial Panel. Abstracts, book chapters, white papers, advertising material, instructional manuals, and non-peer reviewed publications are not allowed to accompany application submissions, and will not be accepted as substitutes for full-length journal articles. Any “in press” manuscripts that are submitted will only be appropriate for consideration by the Panel if accompanied by the letter from the editor/publisher of the applicable journal informing the author that the manuscript has been accepted for publication in its final form, subject only to final copy editing. It is the

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responsibility of the submitter to ensure that such submission to the CPT Editorial Panel (despite its very limited use by the Editorial Panel) does not jeopardize publication of the article being considered and such text be available for Panel use.

4. Well-designed studies submitted for consideration should represent the most informative and compelling peer-reviewed publications that directly support the application. Therefore, it is assumed that the requestors are endorsing studies that are well-designed and executed, ethical in nature, and directly supports the code change request. Foreign and mixed (i.e., U.S. & foreign) studies submitted to meet the literature requirements will be judged by the same criteria as U.S. based studies.
5. If this request is an “Editorial Only” change, or has been referred by the RUC for editorial change by the CPT Editorial Panel and has been reviewed and approved through the CPT/RUC process within the last 5 (five) years, the requestors may choose not to submit literature. However, the referral letter from RUC or CMS should accompany the submission for full explanation. If the Editorial Panel determines that supporting literature is required for the editorial change application, then this application will not be considered by the full Editorial Panel until the necessary literature is submitted.

[General guidelines for article inclusion and literature requirements](#)

Below you will be asked to upload the corresponding literature for each code requested.

(You will be able to include additional citations once you have completed the file upload)

[For all citations, choose one Technology response and one Utilization]

[For each citation, enter the following]

- Associated code(s)
- Copy/Paste Article Title, Journal Name, Author(s) Name(s), and Year of Publication [Textbox]
- For the citation you referenced above, please upload an electronic (PDF or Word documents) copy(s) of the literature to support your application. [File upload]
- Level of Evidence [One-selection dropdown]
 - Ia – Systematic review of RCT
 - Ib - Individual RCT
 - IIa – Systematic review of cohort studies
 - IIb – Individual cohort study

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- IIIa – Systematic review of case control studies
 - IIIb – Case control study
 - IV – Case series
 - V – Expert opinion
- Society or Organization with Editorial Responsibility for Publication [Textbox]
 - Total patients studied [Textbox]
 - Relevance Statement [Textbox]

Conflicting Reference Citations

Have you found any publications, in addition to those cited in the Code Change Application, which offer conflicting data or different opinions, and that you feel are important for Editorial Panel consideration in evaluating this code change application? If so, please provide the literature reference, level of evidence and reason that you consider the publication(s) relevant, and why you excluded them from the articles cited in Reference Citations (V. 7).

Please provide electronic (PDF or Word documents) copy(s) (and internet addresses, if available) of literature to support your application, and cite the author, title, journal, year, volume and page(s) below.

Once a citation has been added, you can edit or delete it at any time. To edit an existing citation, choose the citation you'd like to edit in the "Created Citations List" on the right side of the page. Any previous information that was saved will populate the screen. To delete a citation, select the "X" icon on a citation in the "Created Citations List."

[For each citation, enter the following]

- Copy / Paste ONE Citation Here [Textbox]
- For the citation you referenced above, please upload an electronic (PDF or Word documents) copy(s) of the literature to support your application [File upload]

File Uploader:

Drag and Drop Files Here:

FILE DROP ZONE

OR [Choose Files](#) | No file chosen

Other Comments

- Freeform textbox

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DRAFT

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