



Medical Coverage Policy

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Category III Current Procedural Terminology (CPT®) codes

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INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses CPT® Category III Codes, which are a set of temporary (T) codes for emerging technologies, services, and procedures. They have an alpha character as the 5th character in the string (i.e., four digits followed by the letter T) and are also referred to as T Codes. There may be some T codes that are considered medically appropriate based on peer-reviewed scientific literature. Certain T codes which may be recommended for coverage if coverage criteria are met are addressed in the relevant coverage policies listed under the Related Coverage Resources heading above. Therefore, unless there is a Cigna Coverage Policy that specifically extends coverage to a particular Category III code, the code would generally be considered experimental, investigational, or unproven.

Coverage Policy

Because of the specific purpose CPT Category III codes serve for data collection, the items, services or procedures represented by Category III codes are considered experimental, investigational or unproven, unless coverage for a particular Category III code is separately addressed in a Cigna Coverage Policy.

Please refer to Related Coverage Resources above for additional policies that address Category III codes.

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Experimental/Investigational/Unproven:

CPT®* Codes	Description
0207T	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral
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	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; bilateral
0342T	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real-time intraoperative
0439T	Myocardial contrast perfusion echocardiography; at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells
0525T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; complete system (electrode and implantable monitor)
0546T	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report
0559T	Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure
0560T	Anatomic model 3D-printed from image data set(s); each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure)
0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide
0582T	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance

CPT®* Codes	Description
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
0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous
0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open
0608T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (eg, ECG data), transmitted to a remote 24-hour attended surveillance center; analysis of data received and transmission of reports to the physician or other qualified health care professional
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
0643T	Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed, arterial approach
0644T	Transcatheter removal or debulking of intracardiac mass (eg, vegetations, thrombus) via suction (eg, vacuum, aspiration) device, percutaneous approach, with intraoperative reinfusion of aspirated blood, including imaging guidance, when performed
0647T	Insertion of gastrostomy tube, percutaneous, with magnetic gastropexy, under ultrasound guidance, image documentation and report
0659T	Transcatheter intracoronary infusion of supersaturated oxygen in conjunction with percutaneous coronary revascularization during acute myocardial infarction, including catheter placement, imaging guidance (eg, fluoroscopy), angiography, and radiologic supervision and interpretation
0686T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance
0689T	Quantitative ultrasound tissue characterization (nonelastographic), including interpretation and report, obtained without diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target structure)
0724T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)

CPT®* Codes	Description
0742T	Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure)
0794T	Patient-specific, assistive, rules-based algorithm for ranking pharmaco-oncologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology, immunohistochemical, or other pathology results which have been previously interpreted and reported separately
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach
0807T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report
0808T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report
0882T	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, upper extremity, minimum of 10 minutes; initial nerve (List separately in addition to code for primary procedure)
0883T	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, upper extremity, minimum of 10 minutes; each additional nerve (List separately in addition to code for primary procedure)
0888T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including imaging guidance
0947T	Magnetic resonance image guided low intensity focused ultrasound (MRgFUS), stereotactic blood-brain barrier disruption using microbubble resonators to increase the concentration of blood-based biomarkers of target, intracranial, including stereotactic navigation and frame placement, when performed
0956T	Partial craniectomy, channel creation, and tunneling of electrode for sub-scalp implantation of an electrode array, receiver, and telemetry unit for continuous bilateral electroencephalography monitoring system, including imaging guidance
0957T	Revision of sub-scalp implanted electrode array, receiver, and telemetry unit for electrode, when required, including imaging guidance (Do not report 0957T in conjunction with 0958T, 0960T)
0959T	Removal or replacement of magnet from coil assembly that is connected to continuous bilateral electroencephalography monitoring system, including imaging guidance
0960T	Replacement of sub-scalp implanted electrode array, receiver, and telemetry unit with tunneling of electrode for continuous bilateral electroencephalography monitoring system, including imaging guidance (Do not report 0960T in conjunction with 0957T, 0958T)

CPT®* Codes	Description
0967T	Transanal insertion of endoluminal temporary colorectal anastomosis protection device, including vacuum anchoring component and flexible sheath connected to external vacuum source and monitoring system
0968T	Insertion or replacement of epicranial neurostimulator system, including electrode array and pulse generator, with connection to electrode array (For insertion of cranial neurostimulator pulse generator or receiver other than skull mounted, see 61885, 61886) (For revision of cranial neurostimulator pulse generator or receiver other than skull mounted, use 61888) (For insertion of skull-mounted cranial neurostimulator pulse generator or receiver, use 61889)
0970T	Ablation, benign breast tumor (eg, fibroadenoma), percutaneous, laser, including imaging guidance when performed, each tumor (Do not report 0970T in conjunction with 76641, 76642, 76940, 76942) (Report 0970T only once per tumor) (For cryosurgical ablation of fibroadenoma, use 19105) (For cryoablation of malignant breast tumor[s], use 0581T) (For laser ablation of malignant breast tumor[s], use 0971T)
0977T	Upper gastrointestinal blood detection, sensor capsule, with interpretation and report
0978T	Submucosal cryolysis therapy; soft palate, base of tongue, and lingual tonsil
0979T	Submucosal cryolysis therapy; soft palate only
0980T	Submucosal cryolysis therapy; base of tongue and lingual tonsil only (Do not report Submucosal cryolysis therapy; base of tongue and lingual tonsil only
0990T	Transcervical instillation of biodegradable hydrogel materials, intrauterine
0991T	Cystourethroscopy, with low-energy lithotripsy and acoustically actuated microspheres, including imaging
0994T	Endovascular delivery of aortic wall stabilization drug therapy through a sheath positioned within an abdominal aortic aneurysm, with aortic roadmapping, balloon occlusion, imaging guidance, and radiological supervision and interpretation; percutaneous
0995T	Endovascular delivery of aortic wall stabilization drug therapy through a sheath positioned within an abdominal aortic aneurysm, with aortic roadmapping, balloon occlusion, imaging guidance, and radiological supervision and interpretation; open
0999T	Autologous muscle cell therapy, harvesting of muscle progenitor cells, including ultrasound guidance, when performed
1000T	Autologous muscle cell therapy, administration of muscle progenitor cells into the urethral sphincter, including cystoscopy and post-void residual ultrasound, when performed
1001T	Autologous muscle cell therapy, injection of muscle progenitor cells into the external anal sphincter, including ultrasound guidance, when performed
1003T	Arthroplasty, first carpometacarpal joint, with distal trapezial and proximal first metacarpal prosthetic replacement (eg, first carpometacarpal total joint)
1025T	Alternating electric fields dosimetry and delivery-simulation modeling, creation and selection of patient-specific array layouts, and placement verification

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General Background

CPT Category III codes are a set of temporary (T) codes assigned to emerging technologies, services, and procedures. These codes are intended to be used for data collection to substantiate more widespread usage or to provide documentation for the Food and Drug Administration (FDA) approval process. Category III codes can be identified by the T alpha character that follows the four initial numerical digits (i.e., four digits followed by the letter T). These codes are also referred to as T Codes (American Medical Association [AMA], 2019).

The use of a Category III code allows physicians and other qualified health care professionals to identify emerging technologies, services and procedures for clinical efficacy, utilization and outcomes. Category III codes are generally archived after five years and may or may not eventually receive a Category I CPT code. If a specific cross-referenced Category I code has not been established at the time of archiving, the service or procedure will be reported with a Category I unlisted code (AMA, 2019).

It is noted by the AMA that a service or procedure represented by a T code does not constitute a finding of support, or lack thereof with regard to clinical efficacy, safety, applicability or clinical practice. Typically, there is a lack of published, peer-review evidence supporting the clinical efficacy, safety, and applicability of these services to clinical practice nor are these services considered an established standard of care.

Related Coverage Policies that consider specific Category III codes medically necessary for some indications include the following:

Coverage Policy	Category III CPT Code(s)
Ambulatory External and Implantable Electrocardiographic Monitoring	0650T
Behavioral Health Coaching and Peer Support Services	0591T, 0592T
Brexucabtagene autoleucel	0537T, 0538T, 0539T, 0540T
Diabetes Equipment and Supplies	0446T, 0447T, 0448T
Glaucoma Surgical Procedures	0449T, 0671T
eviCore Pediatric Cardiac Imaging guideline	0501T, 0502T, 0503T, 0504T
eviCore Adult Head Imaging guideline	0042T
Idcabtagene vicleucel	0537T, 0538T, 0539T, 0540T
Intensive Behavioral Interventions	0362T, 0373T
Lisocabtagene maraleucel	0537T, 0538T, 0539T, 0540T
Pancreatic Islet Cell Transplantation	0584T, 0585T, 0586T
Preventive Care Services	0403T, 0488T, 0500T
Scar Revision	0479T, 0480T
Tisagenlecleucel	0537T, 0538T, 0539T, 0540T
Transcatheter Heart Valve Procedures	0483T
Yescarta (Injectable CAR-T)	0537T, 0538T, 0539T, 0540T

Health Equity Considerations

Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work, and age.

Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation, and neighborhoods; racism, discrimination and violence; education, job

opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

References

1. Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

Revision Details

Type of Revision	Summary of Changes	Date
Focused Review	No clinical policy statement changes.	4/15/2025
Focused Review	No clinical policy statement changes.	10/15/2025
Annual Review	No clinical policy statement changes.	8/15/2025
Focused Review	No clinical policy statement changes.	4/15/2025
Focused Review	No clinical policy statement changes.	2/15/2025
Focused Review	Revised policy statement.	12/15/2024
Annual Review	No clinical policy statement changes.	8/15/2024

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