NEW YORK STATE

MEDICAID PROGRAM

PHYSICIAN – PROCEDURE CODES

SECTION 5 - SURGERY

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SURGERY SECTION

GENERAL INFORMATION AND RULES

1. **FEES**: The fees are listed in the Physician Surgery Fee Schedule, available at https://www.emedny.org/ProviderManuals/Physician/index.aspx
   Listed fees are the maximum reimbursable Medicaid fees. Fees for the MOMS Program can be found in the Enhanced Program fee schedule. Fees for office, home and hospital visits, consultations and other medical services are listed in the Fee Schedule entitled MEDICINE.

2. **FOLLOW-UP (F/U) DAYS**:
   Listed dollar values for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column headed "F/U Days". Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis. (See modifier -24)

3. **BY REPORT**:
   When the value of a procedure is indicated as "By Report" (BR), an Operative Report must be submitted with the MMIS claim form for a payment determination to be made. The Operative Report must include the following information:
   a. Diagnosis (post-operative)
   b. Size, location and number of lesion(s) or procedure(s) where appropriate
   c. Major surgical procedure and supplementary procedure(s)
   d. Whenever possible, list the nearest similar procedure by number according to these studies
   e. Estimated follow-up period
   f. Operative time

   Failure to submit an Operative Report when billing for a "By Report" procedure will cause your claim to be denied by MMIS.

4. **ADDITIONAL SERVICES**:
   Complications or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional charges on a fee-for-service basis. (See modifiers -24, -25, -79). When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations. (See modifiers -78, -79)

5. **SEPARATE PROCEDURE**:
   Certain of the listed procedures are commonly carried out as an integral part of a total service and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "Separate Procedure" is applicable.
6. **MULTIPLE SURGICAL PROCEDURES**:
   a. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total dollar value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s) unless otherwise specified. (For reporting bilateral surgical procedures, see modifier -50).

b. When an incidental procedure (eg, incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the fee will be that of the major procedure only.

7. **PROCEDURES NOT SPECIFICALLY LISTED**:
Will be given values comparable to those of the listed procedures of closest similarity. When no similar procedure can be identified, the MMIS procedure codes to be utilized may be found at the end of each section.

8. **SUPPLEMENTAL SKILLS**:
When warranted by the necessity of supplemental skills, values for services rendered by two or more physicians will be allowed.

9. **SKILLS OF TWO SURGEONS**
   a. When the skills of two surgeons are required in the management of a specific surgical procedure, by prior agreement, the total dollar value may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. The value may be increased by 25 percent under these circumstances. See MMIS modifier -62.
   b. **PHYSICIAN ASSISTANT/ NURSE PRACTITIONER /RN FIRST ASSISTANT (RNFA) SERVICES FOR ASSIST AT SURGERY**: When a physician requests a nurse practitioner, a physician's assistant or an Registered Nurse First Assistant to participate in the management of a specific surgical procedure in lieu of another physician, **or requests a licensed midwife to participate in the management of a Cesarean section**, by prior agreement, the total value may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. The value may be increased by 20 percent under these circumstances. The claim for these services will be submitted by the physician using the appropriate modifier.

10. **MATERIALS SUPPLIED BY A PHYSICIAN**:
Supplies and materials provided by the physician, eg, sterile trays/drugs, **over and above** those usually included with the office visit or other services rendered may be listed separately. List drugs, trays, supplies and materials provided. Identify as **99070**.
Reimbursement for drugs (including vaccines and immunoglobulin) furnished by practitioners to their patients is based on the acquisition cost to the practitioner of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the practitioner will maintain auditable records of the actual itemized invoice cost of the drug, including the numbers of doses of the drug represented on the invoice. New York State Medicaid does not intend to pay more than the acquisition cost of the drug dosage, as established by invoice, to the practitioner. Regardless of whether an invoice must be submitted to Medicaid for payment, the practitioner is expected to limit his or her Medicaid claim amount to the actual invoice cost of the drug dosage administered.

11. **PRIOR APPROVAL**:
Payment for those listed procedures where the MMIS code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.

12. **DVS AUTHORIZATION (#):**
Codes followed by **#** require an authorization via the dispensing validation system (DVS) before services are rendered.

13. **INFORMED CONSENT FOR STERILIZATION**:
When procedures are performed for the primary purpose of rendering an individual incapable of reproducing, and in all cases when procedures identified by MMIS codes 55250, 55450, 58565, 58600, 58605, 58611, 58615, 58670 and 58671 are performed, the following rules will apply:
a. The patient must be 21 years of age or older at the time to consent to sterilization.
b. The patient must have been informed of the risks and benefits of sterilization and have signed the mandated consent form, (DSS-3134) not less than 30 days nor more than 180 days prior to the performance of the procedure. In cases of premature delivery and emergency abdominal surgery, consent must have been given at least 72 hours prior to sterilization.
c. No bill will be processed for payment without a properly completed consent form. (Refer to Billing Section for completion instructions).

NOTE: For procedures performed within the jurisdiction of NYC the guidelines established under NYC Local Law #37 of 1977 continue to be in force.

14. **RECEIPT OF HYSTERECTOMY INFORMATION**:
Hysterectomies must not be performed for the purpose of sterilization. When hysterectomy procedures are performed and in all cases when procedures identified by MMIS codes 51925, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58294, 58541, 58542, 58543, 58544, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58951, 58953, 58954, 58956, 59135, or 59525 are billed, a properly completed "Hysterectomy Receipt of Information Form" must be attached to the bill for payment. No bill will be processed without a properly completed "Hysterectomy Receipt of Information Form", (DSS-3113).

15. **BILLING GUIDELINES**:
For additional general billing guidelines see the current CPT manual.

16. **MMIS SURGERY MODIFIERS**:
Note: NCCI associated modifiers are recognized for NCCI code pairs/related edits. For additional information please refer to the CMS website:
http://www.cms.hhs.gov/NationalCorrectCodInitEd/

-50 Bilateral Procedure (Surgical): Unless otherwise identified in the listings, bilateral surgical procedures requiring a separate incision that are performed at the same operative session, should be identified by the appropriate five digit code describing the first procedure. To indicate a bilateral surgical procedure was done add modifier -50 to the procedure number.

(Reimbursement will not exceed 150% of the maximum Fee Schedule amount. One claim line is to be billed representing the bilateral procedure. Amount billed should reflect total amount due.)

-54 Surgical Care Only: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier -54 to the usual procedure number. (Reimbursement will not exceed 80% of the maximum Fee Schedule amount.)

-62 Two Surgeons: When two surgeons (usually of different skills) work together as primary surgeons performing distinct part(s) of a single reportable procedure, add the modifier –62 to the single definitive procedure code. [One surgeon should file one claim line representing the procedure performed by the two surgeons. Reimbursement will not exceed 125% of the maximum State Medical Fee Schedule amount.] If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may be reported without the modifier –62 added as appropriate. **NOTE**: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with the modifier –80 added, as appropriate.

-63 Procedure Performed on Infants Less Than 4 kg: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding modifier –63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 69999 code series. Modifier –63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections. (Reimbursement will not exceed 100% of the maximum Fee Schedule amount.)

-66 Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of the modifier -66 to the basic procedure number used for reporting services. (Reimbursement will not exceed 20% of the maximum Fee Schedule amount.)

-78 Return to the Operating Room for a Related Procedure During the Postoperative Period: The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier -78 to the related procedure. (Reimbursement will not exceed 100% of the maximum Fee Schedule amount.)

-79 Unrelated Procedure or Service by the Same Practitioner During the Postoperative Period: The practitioner may need to indicate that the performance of a procedure or service during

the postoperative period was unrelated to the original procedure. This circumstance may be reported by adding the modifier -79. (Reimbursement will not exceed 100% of the maximum Fee Schedule amount.)

-80 Assistant Surgeon: Surgical assistant services may be identified by adding the modifier -80 to the usual procedure number(s). (Reimbursement will not exceed 20% of the maximum Fee Schedule amount.)

-82 Assistant Surgeon: (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier -82 appended to the usual procedure code number(s). (Reimbursement will not exceed 20% of the maximum Fee Schedule amount.)

-AQ Physician Providing a Service in an Unlisted Health Professional Shortage Area (HPSA)

-AS Physician Assistant, Nurse Practitioner or Registered Nurse First Assistant Services for Assist at Surgery: When the physician requests that a Physician Assistant, a Nurse Practitioner, or an Registered Nurse First Assistant to assist at surgery, or requests a licensed midwife to assist for a Cesarean section, in lieu of another physician, Modifier -AS should be added to the appropriate code describing the procedure. One claim is to be filed. (Reimbursement will not exceed 120% of the maximum Fee Schedule amount).

-LT Left Side (used to identify procedures performed on the left side of the body): Add modifier –LT to the usual procedure code number. (Reimbursement will not exceed 100% of the Maximum Fee Schedule amount. One claim line should be billed.) (Use modifier –50 when both sides done at same operative session.)

-RT Right Side (used to identify procedures performed on the right side of the body): Add modifier –RT to the usual procedure code number. (Reimbursement will not exceed 100% of the Maximum Fee Schedule amount. One claim line should be billed.) (Use modifier –50 when both sides done at same operative session.)

SURGERY SERVICES

GENERAL

10021 Fine needle aspiration biopsy, without imaging guidance; first lesion
10004 each additional lesion (List separately in addition to code for primary procedure)
10005 Fine needle aspiration biopsy, including ultrasound guidance; first lesion
10006 each additional lesion (List separately in addition to code for primary procedure)
10007 Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion
10008 each additional lesion (List separately in addition to code for primary procedure)
10009 Fine needle aspiration biopsy, including CT guidance; first lesion
10010 each additional lesion (List separately in addition to code for primary procedure)
10011 Fine needle aspiration biopsy, including MR guidance; first lesion
10012 each additional lesion (List separately in addition to code for primary procedure)

INTERGUMENTARY SYSTEM

SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES

INCISION AND DRAINAGE

10030 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous
10035 Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion
10036 each additional lesion (List separately in addition to code for primary procedure) (Do not report 10035, 10036 in conjunction with 76942, 77002, 77012 77021)
10040 Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
10060 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10061 complicated or multiple
10080 Incision and drainage of pilonidal cyst; simple
10081 complicated
10120 Incision and removal of foreign body, subcutaneous tissues; simple
10121 complicated
10140 Incision and drainage of hematoma, seroma or fluid collection
10160 Puncture aspiration of abscess, hematoma, bulla or cyst
10180 Incision and drainage, complex, postoperative wound infection

EXCISION – DEBRIDEMENT

11000 Debridement of extensive eczematous or infected skin; up to 10% of body surface
11001 each additional 10% of the body surface, or part thereof (List separately in addition to primary procedure) (Use 11001 in conjunction with 11000)

11004 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum
11005 abdominal wall, with or without fascial closure
11006 external genitalia, perineum and abdominal wall, with or without fascial closure
11008 Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection)
(List separately in addition to primary procedure)
(Use 11008 in conjunction with 10180, 11004-11006)
(Do not report 11008 in conjunction with 11000-11001, 11010-11044)
(Report skin grafts or flaps separately when performed for closure at the same session as 11004-11008)
11010 Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues
11011 skin, subcutaneous tissue, muscle fascia, and muscle
11012 skin, subcutaneous tissue, muscle fascia, muscle, and bone
11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
11043 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle, and/or fascia, if performed); first 20 sq cm or less
11045 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof
(List separately in addition to primary procedure)
(Use 11045 in conjunction with 11042)
11046 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof
(List separately in addition to primary procedure
(Use 11046 in conjunction with 11043)
11047 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle, and/or fascia, if performed); each additional 20 sq cm, or part thereof
(List separately in addition to primary procedure)
(Use 11047 in conjunction with 11044)

PARING OR CUTTING

11055 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11056 two to four lesions
11057 more than four lesions

BIOPSY

During certain surgical procedures in the integumentary system, such as excision, destruction, or shave removals, the removed tissue is often submitted for pathologic examination. The obtaining of tissue for pathology during the course of these procedures is a routine component of such procedures. This obtaining of tissue is not considered a separate biopsy procedure and is not separately reported. The use of a biopsy procedure code (eg, 11102, 11103, 11104, 11105, 11106, 11107) indicates that the procedure to obtain tissue soley for diagnostic histopathologic examination was performed independently, or was unrelated or distinct from other procedure/service provided at that time. Biopsies performed on different lesions or different sites on the same date of service may be reported separately, as they are not considered components of other procedures.

11102 Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion
11103 each separate/additional lesion (List separately in addition to code for primary procedure)
11104 Punch biopsy of skin (including simple closure, when performed); single lesion
11105 each separate/additional lesion (List separately in addition to code for primary procedure)
11106 Incisional biopsy of skin (eg, wedge) (including simple skin closure, when performed); single lesion
11107 each separate/additional lesion (List separately in addition to code for primary procedure)

REMOVAL OF SKIN TAGS

Removal by scissoring, or any sharp method, ligature strangulation electrosurgical destruction or combination of treatment modalities including chemical or electrocauterization of wound, with or without local anesthesia.

11200 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201 each additional ten lesions, or part thereof
(List separately in addition to primary procedure)
(Use 11201 in conjunction with 11200)

SHAVING OF EPIDERMAL OR DERMAL LESIONS

Shaving is the sharp removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full thickness dermal excision. This includes local anesthesia, chemical or electrocauterization of the wound. The wound does not require suture closure.

11300 Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm. or less
11301 lesion diameter 0.6 to 1.0 cm
11302 lesion diameter 1.1 to 2.0 cm
11303 lesion diameter over 2.0 cm
11305 Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
11306 lesion diameter 0.6 to 1.0 cm

11307 lesion diameter 1.1 to 2.0 cm
11308 lesion diameter over 2.0 cm
11310 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
11311 lesion diameter 0.6 to 1.0 cm
11312 lesion diameter 1.1 to 2.0 cm
11313 lesion diameter over 2.0 cm

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 electrosurgical and other methods, see 17000 et seq.

Excision is defined as full thickness (through the dermis) removal of a lesion, including margins, and includes simple (non-layered) closure when performed. Report separately each benign lesion excised. Code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required equals the excised diameter). The margins refer to the most narrow margin required to adequately excise the lesion, based on the physician's judgment. The measurement of lesion plus margin is made prior to excision.

The excised diameter is the same whether the surgical defect is repaired in a linear fashion, or reconstructed (eg, with a skin graft).

The closure of defects created by incision, excision, or trauma may require intermediate or complex closure. Repair by intermediate or complex closure should be reported separately.

11400 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401 excised diameter 0.6 to 1.0 cm
11402 excised diameter 1.1 to 2.0 cm
11403 excised diameter 2.1 to 3.0 cm
11404 excised diameter 3.1 to 4.0 cm
11406 excised diameter over 4.0 cm
11420 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421 excised diameter 0.6 to 1.0 cm
11422 excised diameter 1.1 to 2.0 cm
11423 excised diameter 2.1 to 3.0 cm
11424 excised diameter 3.1 to 4.0 cm
11426 excised diameter over 4.0 cm
11440 Excision, other benign lesion including margins, (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441 excised diameter 0.6 to 1.0 cm

11442 excised diameter 1.1 to 2.0 cm
11443 excised diameter 2.1 to 3.0 cm
11444 excised diameter 3.1 to 4.0 cm
11446 excised diameter over 4.0 cm
11450 Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair
11451 with complex repair
11462 Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair
11463 with complex repair
11470 Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal or umbilical; with simple or intermediate repair
11471 with complex repair
(For bilateral procedure, add modifier 50)

EXCISION - MALIGNANT LESIONS

Excision (including simple closure) of malignant lesions of skin (eg, basal cell carcinoma, squamous cell carcinoma, melanoma) includes local anesthesia. (See appropriate size and body area below). For destruction of malignant lesions of skin, see destruction codes 17260-17286.

Excision is defined as full-thickness (through the dermis) removal of a lesion including margins, and includes simple (non-layered) closure when performed. Report separately each malignant lesion excised. Code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required equals the excised diameter). The margins refer to the most narrow margin required to adequately excise the lesion, based on the physician's judgment. The measurement of lesion plus margin is made prior to excision. The excised diameter is the same whether the surgical defect is repaired in a linear fashion, or reconstructed (eg, with a skin graft).

The closure of defects created by incision, excision, or trauma may require intermediate or complex closure. Repair by intermediate or complex closure should be reported separately. For excision of malignant lesions requiring more than simple closure, i.e., requiring intermediate or complex closure, report 11600-11646 in addition to appropriate intermediate (12031-12057) or complex closure (13100-13153) codes. For reconstructive closure, see, 15002-15261, 15570-15770. See definition of intermediate or complex closure.

When frozen section pathology shows the margins of excision were not adequate, an additional excision may be necessary for complete tumor removal. Use only one code to report the additional excision and re-excision(s) based on the final widest excised diameter required for complete tumor removal at the same operative session.

To report a re-excision procedure performed to widen margins at a subsequent operative session, see codes 11600-11646, as appropriate.

11600 Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 0.5 cm or less

11601 excised diameter 0.6 to 1.0 cm
11602 excised diameter 1.1 to 2.0 cm
11603 excised diameter 2.1 to 3.0 cm
11604 excised diameter 3.1 to 4.0 cm
11606 excised diameter over 4.0 cm
11620 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11621 excised diameter 0.6 to 1.0 cm
11622 excised diameter 1.1 to 2.0 cm
11623 excised diameter 2.1 to 3.0 cm
11624 excised diameter 3.1 to 4.0 cm
11626 excised diameter over 4.0 cm
11640 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less
11641 excised diameter 0.6 to 1.0 cm
11642 excised diameter 1.1 to 2.0 cm
11643 excised diameter 2.1 to 3.0 cm
11644 excised diameter 3.1 to 4.0 cm
11646 excised diameter over 4.0 cm

NAILS

11720 Debridement of nail(s) by any method(s); one to five
11721 six or more
11730 Avulsion of nail plate, partial or complete, simple; single
11732 each additional nail plate
(List separately in addition to primary procedure)
(Use 11732 in conjunction with 11730)
11740 Evacuation of subungual hematoma
11750 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;
11755 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)
11760 Repair of nail bed
11762 Reconstruction of nail bed with graft
11765 Wedge excision of skin of nail fold (eg, for ingrown toenail)

PILONIDAL CYST

11770 Excision of pilonidal cyst or sinus; simple
11771 extensive
11772 complicated

INTRODUCTION

11900 Injection, intralesional; up to and including seven lesions

11901 more than seven lesions
(11900, 11901 are not to be used for preoperative local anesthetic injection)
11920 Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921 6.1 to 20.0 sq cm
11922 each additional 20.0 sq cm, or part thereof
(List separately in addition to primary procedure)
(Use 11922 in conjunction with 11921)
11950 Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951 1.1 to 5 cc
11952 5.1 to 10 cc
11954 over 10 cc
11960 Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970 Replacement of tissue expander with permanent implant
11971 Removal of tissue expander without insertion of implant
11976 Removal, implantable contraceptive capsules
11980 Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
11981 Insertion, non-biodegradable drug delivery implant
11982 Removal, non-biodegradable drug delivery implant
11983 Removal with reinsertion, non-biodegradable drug delivery implant

REPAIR (CLOSURE)

Use the codes in this section to designate wound closure utilizing sutures, staples, or tissue adhesives (eg, 2-cyanoacrylate), either singly or in combination with each other, or in combination with adhesive strips. Wound closure utilizing adhesive strips as the sole repair material should be coded using the appropriate E/M code.

DEFINITIONS:

The repair of wounds may be classified as Simple, Intermediate or Complex.

SIMPLE REPAIR: is used when the wound is superficial; ie, involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure. This includes local anesthesia and chemical or electrocauterization of wounds not closed. (For closure with adhesive strips, list appropriate Evaluation and Management service only).

INTERMEDIATE REPAIR: includes the repair of wounds that, in addition to the above, require layer closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.

COMPLEX REPAIR: includes the repairs of wounds requiring more than layered closure, viz., scar revision, debridement, (eg, traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. Necessary preparation includes creation of a defect for repairs (eg, excision of a

scar requiring a complex repair) or the debridement of complicated lacerations or avulsions. Complex repair does not include excision of benign (11400-11446) or malignant (11600-11646) lesions.

Instructions for listing services at time of wound repair:

1. The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular or stellate.
2. When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and from all anatomic sites that are grouped together into the same code descriptor. For example, add together the lengths of intermediate repairs to the trunk and extremities. Do not add lengths of repairs from different groupings of anatomic sites (eg, face and extremities). Also, do not add together lengths of different classifications (eg, intermediate and complex repairs).
3. Decontamination and/or debridement: Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure. (For extensive debridement of soft tissue and/or bone, see 11044)
   (For extensive debridement of soft tissue and/or bone, not associated with open fracture(s) and/or dislocation(s) resulting from penetrating and/or blunt trauma, see 11044.)
   (For extensive debridement of subcutaneous tissue, muscle fascia, muscle, and/or bone associated with open fracture(s) and/or dislocation(s), see 11010-11012.)
4. Involvement of nerves, blood vessels and tendons: Report under appropriate system (Nervous, Cardiovascular, Musculoskeletal) for repair of these structures. The repair of these associated wounds is included in the primary procedure.
   Simple ligation of vessels in an open wound is considered as part of any wound closure.
   Simple exploration of nerves, blood vessels or tendons exposed in an open wound is also considered part of the essential treatment of the wound and is not a separate procedure unless appreciable dissection is required. If the wound requires enlargement, extension of dissection (to determine penetration), debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s), of the subcutaneous tissue, muscle, fascia, and/or muscle, not requiring thoracotomy or laparotomy, use codes 20100-20103, as appropriate.

REPAIR-SIMPLE

12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
12002 2.6 cm to 7.5 cm
12004 7.6 cm to.12.5 cm
12005 12.6 cm to 20.0 cm
12006 20.1 cm to 30.0 cm
12007 over 30.0 cm
12011 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12013 2.6 cm to 5.0 cm
12014 5.1 cm to 7.5 cm
12015 7.6 cm to 12.5 cm
12016 12.6 cm to 20.0 cm
12017 20.1 cm to 30.0 cm

12018 over 30.0 cm
12020 Treatment of superficial wound dehiscence; simple closure

REPAIR-INTERMEDIATE

12031 Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less
12032 2.6 cm to 7.5 cm
12034 7.6 cm to.12.5 cm
12035 12.6 cm to 20.0 cm
12036 20.1 cm to 30.0 cm
12037 over 30.0 cm
12041 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less
12042 2.6 cm to 7.5 cm
12044 7.6 cm to.12.5 cm
12045 12.6 cm to 20.0 cm
12046 20.1 cm to 30.0 cm
12047 over 30.0 cm
12051 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12052 2.6 cm to 5.0 cm
12053 5.1 cm to 7.5 cm
12054 7.6 cm to 12.5 cm
12055 12.6 cm to 20.0 cm
12056 20.1 cm to 30.0 cm
12057 over 30.0 cm

REPAIR-COMPLEX

13100 Repair, complex, trunk; 1.1 cm to 2.5 cm
13101 2.6 cm to 7.5 cm
13102 each additional 5 cm or less
(List separately in addition to primary procedure)
(Use 13102 in conjunction with 13101)
13120 Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121 2.6 cm to 7.5 cm
13122 each additional 5 cm or less
(List separately in addition to primary procedure)
(Use 13122 in conjunction with 13121)
13131 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132 2.6 cm to 7.5cm
13133 each additional 5 cm or less
(List separately in addition to primary procedure)
(Use 13133 in conjunction with 13132)

13151 Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm
13152 2.6 cm to 7.5 cm
13153 each additional 5 cm or less
(List separately in addition to primary procedure)
(Use 13153 in conjunction with 13152)
13160 Secondary closure of surgical wound or dehiscence, extensive or complicated

ADJACENT TISSUE TRANSFER OR REARRANGEMENT

Excision (including lesion) and/or repair by adjacent tissue transfer or rearrangement (eg, Z-plasty, W-plasty, V-Y plasty, rotation flap, advancement flap, double pedicle flap). When applied in repairing lacerations, the procedures listed must be developed by the surgeon to accomplish the repair. They do not apply when direct closure or rearrangement of traumatic wounds incidentally result in these configurations.

Skin graft necessary to close secondary defect is considered an additional procedure. For purposes of code selection, the term “defect’’ includes the primary and secondary defects. The primary defect resulting from the excision and the secondary defect resulting from flap design to perform the reconstruction are measured together to determine the code.

14000 Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001 defect 10.1 sq cm to 30.0 sq cm
14020 Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm. or less
14021 defect 10.1 sq cm to 30.0 sq cm
14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041 defect 10.1 sq cm to 30.0 sq cm
14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061 defect 10.1 sq cm to 30.0 sq cm
14301 Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
14302 each additional 30.0 sq cm, or part thereof
(List separately in addition to code)
(Use 14302 in conjunction with 14301)
14350 Filleted finger or toe flap, including preparation of recipient site

SKIN REPLACEMENT SURGERY

Identify by size and location of the defect (recipient area) and the type of graft or skin substitute; includes simple debridement of granulation tissue or recent avulsion.

When a primary procedure such as orbitectomy, radical mastectomy or deep tumor removal requires skin graft for definitive closure, see appropriate anatomical subsection for primary procedure and this section for skin graft or skin substitute.

Repair of donor site requiring skin graft or local flaps is to be added as an additional procedure.

Codes 15002 and 15005 describe burn and wound preparation or incisional or excisional release of scar contracture resulting in an open wound requiring a skin graft. Code 15100 describe the application of skin replacements and skin substitutes. The following definition should be applied to those codes that reference “100 sq cm or one percent 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 age 10 and over, percentages of body surface area apply to infants and children under the age of 10.

These codes are not intended to be reported for simple graft application alone or application stabilized with dressings (eg, simple gauze wrap) without surgical fixation of the skin substitute/graft. The skin substitute/graft is anchored using the surgeon’s choice of fixation. When services are performed in the office, the supply of the skin substitute/graft should be reported separately. Routine dressing supplies are not reported separately.

SURGICAL PREPARATION

15002 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

15003 each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children
(List separately in addition to primary procedure)
(Use 15003 in conjunction with 15002)

15004 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children

15005 each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children
(List separately in addition to primary procedure)
(Use 15005 in conjunction with 15004)

(Report 15002-15005 in conjunction with code for appropriate skin grafts or replacements [15050-15261,]. List the graft or replacement separately by its procedure number when the graft, immediate or delayed, is applied)

AUTOGRAFT/TISSUE CULTURED AUTOGRAFT

15040 Harvest of skin for tissue cultured skin autograft, 100 sq cm or less

15050 Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter

15100 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)

15101 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to primary procedure)
(Use 15101 in conjunction with 15100)

15110 Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

15111 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to primary procedure)
(Use 15111 in conjunction with 15110)

15115 Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children

15116 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to primary procedure)
(Use 15116 in conjunction with 15115)

15120 Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)

15121 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to primary procedure)
(Use 15121 in conjunction with 15120)

15130 Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

15131 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to primary procedure)
(Use 15131 in conjunction with 15130)

15135 Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children

15136 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to primary procedure)
(Use 15136 in conjunction with 15135)

15150 Tissue cultured skin autograft, trunk, arms, legs; first 25 sq cm or less

15151 additional 1 sq cm to 75 sq cm
(List separately in addition to primary procedure)
(Do not report 15151 more than once per session)
(Use 15151 in conjunction with 15150)

15152 each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof
(List separately in addition to primary procedure)
(Use 15152 in conjunction with 15151)

15155 Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less

15156 additional 1 sq cm to 75 sq cm
(List separately in addition to primary procedure)

(Do not report 15156 more than once per session)
(Use 15156 in conjunction with 15155)

15157 each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof
(List separately in addition to primary procedure)
(Use 15157 in conjunction with 15156)

15200 Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less

15201 each additional 20 sq cm, or part thereof
(List separately in addition to primary procedure)
(Use 15201 in conjunction with 15200)

15220 Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less

15221 each additional 20 sq cm, or part thereof
(List separately in addition to primary procedure)
(Use 15221 in conjunction with 15220)

15240 Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less

15241 each additional 20 sq cm, or part thereof
(List separately in addition to primary procedure)
(Use 15241 in conjunction with 15240)

15260 Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less

15261 each additional 20 sq cm, or part thereof
(List separately in addition to primary procedure)
(Use 15261 in conjunction with 15260)

SKIN SUBSTITUTE GRAFTS

15271 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

15272 each additional 25 sq cm wound surface area, or part thereof
(List separately in addition to primary procedure)
(Use 15272 in conjunction with 15271)

(Do not report 15271, 15272 in conjunction with 15273, 15274)

15273 Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

15274 each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof
(List separately in addition to primary procedure)
(Use 15274 in conjunction with 15273)

15275 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

15276 each additional 25 sq cm wound surface area, or part thereof

(List separately in addition to primary procedure)
(Use 15276 in conjunction with 15275)
(Do not report 15275, 15276 in conjunction with 15277, 15278)

15277 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

15278 each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof
(List separately in addition to primary procedure)
(Use 15278 in conjunction with 15277)

FLAPS (SKIN AND/OR DEEP TISSUES)

Regions listed refer to recipient area (not donor site) when flap is being attached in transfer or to final site.

Regions listed refer to donor site when tube is formed for later transfer or when delay of flap is prior to transfer.

Procedures 15570-15738 do not include extensive immobilization, (eg, large plaster casts and other immobilizing devices are considered additional separate procedures)

Repair of donor site requiring skin graft or local flaps is considered an additional separate procedure.

15570 Formation of direct or tubed pedicle, with or without transfer; trunk
15572 scalp, arms, or legs
15574 forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15576 eyelids, nose, ears, lips, or intraoral
15600 Delay of flap or sectioning of flap (division and inset); at trunk
15610 at scalp, arms, or legs
15620 at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet
15630 at eyelids, nose, ears, or lips
15650 Transfer, intermediate, of any pedicle flap (eg, abdomen to wrist, Walking tube), any location
15730 Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)
15731 Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)
15733 Muscle, myocutaneous or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)
15734 trunk
15736 upper extremity
15738 lower extremity

OTHER FLAPS AND GRAFTS

Repair of donor site requiring skin graft or local flaps should be reported as an additional procedure.

15740 Flap; island pedicle requiring identification and dissection of an anatomically

named axial vessel
15750 neurovascular pedicle
15756 Free muscle or myocutaneous flap with microvascular anastomosis
15757 Free skin flap with microvascular anastomosis
15758 Free fascial flap with microvascular anastomosis
15760 Graft; composite (full thickness of external ear or nasal ala), including primary closure, donor area
15770 derma-fat-fascia
15775 Punch graft for hair transplant; 1 to 15 punch grafts
15776 more than 15 punch grafts
15777 Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk)
(List separately in addition to primary procedure)
(For bilateral breast procedure, report 15777 with modifier 50)

OTHER PROCEDURES

15780 Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781 segmental, face
15782 regional, other than face
15783 superficial, any site, (eg, tattoo removal)
15786 Abrasion; single lesion (eg, keratosis, scar)
15787 each additional four lesions or less
(List separately in addition to primary procedure)
(Use 15787 in conjunction with 15786)
15788 Chemical peel, facial; epidermal
15789 dermal
15792 Chemical peel, nonfacial; epidermal
15793 dermal
15819 Cervicoplasty
15820 Blepharoplasty, lower eyelid;
15821 with extensive herniated fat pad
15822 Blepharoplasty, upper eyelid;
15823 with excessive skin weighting down lid
(For bilateral blepharoplasty, add modifier 50)
15824 Rhytidectomy; forehead
(For bilateral rhytidectomy, add modifier 50)
15825 neck with platysmal tightening (platysmal flap, P-flap)
15826 glabellar frown lines
15828 cheek, chin, and neck
15829 superficial musculoaponeurotic system (SMAS) flap
15830 Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
(Do not report 15830 in conjunction with 12031, 12032, 12034, 12035, 12036, 12037, 13100, 13101, 13102, 14000-14001, 14302)

15832 thigh
15833 leg
15834 hip
15835 buttock
15836 arm
15837 forearm or hand
15838 submental fat pad
15839 other area
(For bilateral procedure, add modifier 50)
15840 Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)
(For bilateral procedure, add modifier 50)
15841 free muscle graft (including obtaining graft)
15842 free muscle flap by microsurgical technique
15845 regional muscle transfer
15847 Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
(List separately in addition to primary procedure)
(Use 15847 in conjunction with 15830)
15851 Removal of sutures under anesthesia (other than local), other surgeon
15852 Dressing change (for other than burns) under anesthesia (other than local) **(See Rule 4)**
15860 Intravenous injection of agent (eg, fluorescein) to test vascular flow in flap or graft
15876 Suction assisted lipectomy; head and neck
15877 trunk
15878 upper extremity
15879 lower extremity

PRESSURE ULCERS (DECUBITIS ULCERS)

15920 Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture
15922 with flap closure
15931 Excision, sacral pressure ulcer, with primary suture;
15933 with ostectomy
15934 Excision, sacral pressure ulcer, with skin flap closure
15935 with ostectomy
15936 Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;
15937 with ostectomy
15940 Excision, ischial pressure ulcer, with primary suture;
15941 with ostectomy
15944 Excision, ischial pressure ulcer, with skin flap closure;
15945 with ostectomy
15946 Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin graft closure
15950 Excision, trochanteric pressure ulcer, with primary suture;
15951 with ostectomy

15952 Excision, trochanteric pressure ulcer, with skin flap closure;
15953 with ostectomy
15956 Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;
15958 with ostectomy
15999 Unlisted procedure, excision pressure ulcer

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 15100.

List percentage of body surface involved and depth of burn.

16000 Initial treatment, first degree burn, when no more than local treatment is required
16020 Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)
16025 medium (eg, whole face or whole extremity or 5% to 10% total body surface area)
16030 large (eg, more than one extremity, or greater than 10% total body surface area)
16035 Escharotomy; initial incision
16036 each additional incision
(List separately in addition to primary procedure)
(Use 16036 in conjunction with code 16035)

DESTRUCTION

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

Any method includes electrosurgery, cryosurgery, laser and chemical treatment. Lesions include condylomata, papillomata, molluscum contagiosum, herpetic lesions, warts (ie, common, plantar, flat), milia, or other benign, pre-malignant (eg, actinic keratoses), or malignant lesions.

DESTRUCTION, BENIGN OR PREMALIGNANT LESIONS

17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); first lesion
17003 second through 14 lesions, each
(List separately in addition to code for first lesion)
(Use 17003 in conjunction with 17000)
17004 15 or more lesions
(Do not report 17004 in addition to 17000 – 17003)
17106 Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
17107 10.0 - 50.0 sq cm
17108 over 50.0 sq cm

17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111 15 or more lesions
17250 Chemical cauterization of granulation tissue (ie,proud flesh)

DESTRUCTION, MALIGNANT LESIONS, ANY METHOD

17260 Destruction, malignant lesion, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less
17261 lesion diameter 0.6 to 1.0 cm
17262 lesion diameter 1.1 to 2.0 cm
17263 lesion diameter 2.1 to 3.0 cm
17264 lesion diameter 3.1 to 4.0 cm
17266 lesion diameter over 4.0 cm
17270 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
17271 lesion diameter 0.6 to 1.0 cm
17272 lesion diameter 1.1 to 2.0 cm
17273 lesion diameter 2.1 to 3.0 cm
17274 lesion diameter 3.1 to 4.0 cm
17276 lesion diameter over 4.0 cm
17280 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
17281 lesion diameter 0.6 to 1.0 cm
17282 lesion diameter 1.1 to 2.0 cm
17283 lesion diameter 2.1 to 3.0 cm
17284 lesion diameter 3.1 to 4.0 cm
17286 lesion diameter over 4.0 cm

MOHS' MICROGRAPHIC SURGERY

Mohs micrographic surgery is a technique for the removal of complex or ill-defined skin cancer with histologic examination of 100% of the surgical margins. It requires a single physician to act in two integrated but separate and distinct capacities: surgeon and pathologist. If either of these responsibilities is delegated to another physician who reports the services separately, these codes should not be reported. The Mohs surgeon removes the tumor tissue and maps and divides the tumor specimen into pieces, and each piece is embedded into an individual tissue block for histopathologic examination. Thus a tissue block in Mohs surgery is defined as an individual tissue piece embedded in a mounting medium for sectioning.

If repair is performed, use separate repair, flap, or graft codes.

17311 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by

the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks

17312 each additional stage after the first stage, up to 5 tissue blocks
(List separately in addition to primary procedure)
(Use 17312 in conjunction with 17311)

17313 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks

17314 each additional stage after the first stage, up to 5 tissue blocks
(List separately in addition to primary procedure)
(Use 17314 in conjunction with 17313)

17315 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to primary procedure)
(Use 17315 in conjunction with 17314)

OTHER PROCEDURES

17340 Cryotherapy (C02 slush, liquid N2) for acne
17360 Chemical exfoliation for acne (eg, acne paste, acid)
17380 Electrolysis epilation, each 30 minutes
17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue

BREAST

INCISION

19000 Puncture aspiration of cyst breast;
19001 each additional cyst
(List separately in addition to primary procedure)
(Use 19001 in conjunction with 19000)
19020 Mastotomy with exploration or drainage of abscess, deep
19030 Injection procedure only for mammary ductogram or galactogram

EXCISION

(To report bilateral procedures, use modifier -50)

Excisional breast surgery includes certain biopsy procedures, the removal of cysts or other benign or malignant tumors or lesions, and the surgical treatment of breast and chest wall malignancies. Biopsy

procedures may be percutaneous or open, and they involve the removal of differing amounts of tissue for diagnosis.

Breast biopsies are reported using codes 19100-19103. The open excision of breast lesions (eg, lesions of the breast ducts, cysts, benign or malignant tumors), without specific attention to adequate surgical margins, with or without the preoperative placement of radiological markers, is reported using codes 19110-19126. Partial mastectomy procedures (eg, lumpectomy, tylectomy, quadrantectomy, or segmentectomy) describe open excisions of breast tissue with specific attention to adequate surgical margins.

Partial mastectomy procedures are reported using codes 19301 or 19302 as appropriate. Documentation for partial mastectomy procedures includes attention to the removal of adequate surgical margins surrounding the breast mass or lesion.

Total mastectomy procedures include simple mastectomy, complete mastectomy, subcutaneous mastectomy, modified radical mastectomy, radical mastectomy, and more extended procedures (eg, Urban type operation). Total mastectomy procedures are reported using codes 19303-19307 as appropriate.

Excisions or resections of chest wall tumors including ribs, with or without reconstruction, with or without mediastinal lymphadenectomy, are reported using codes 19260, 19271, or 19272. Codes

19081 Biopsy, breast, with placement of breast localization devices(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance

19082 each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)

19083 Biopsy, breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance

19084 each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)

19085 Biopsy, breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance

19086 each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)

19100 Biopsy of breast; percutaneous, needle core, not using needle guidance (separate procedure)

19101 open, incisional

19105 Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma (Do not report 19105 in conjunction with 76940, 76942)

19110 Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct

19112 Excision of lactiferous duct fistula

19120 Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, one or more lesions

19125 Excision of breast lesion identified by pre-operative placement of radiological marker, open; single lesion

19126 each additional lesion separately identified by a preoperative radiological maker
(List separately in addition to primary procedure)
(Use 19126 in conjunction with code 19125)
(Do not report in conjunction with 32100, 32503, 32504, 32551, 32554, 32555)

INTRODUCTION

19281 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including mammographic guidance

19282 each additional lesion, including mammographic guidance
(List separately in addition to primary procedure)

19283 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including stereotactic guidance

19284 each additional lesion, including stereotactic guidance
(List separately in addition to primary procedure)

19285 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including ultrasound guidance

19286 each additional lesion, including ultrasound guidance
(List separately in addition to primary procedure)

19287 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including magnetic resonance guidance

19288 each additional lesion, including magnetic resonance guidance
(List separately in addition to primary procedure)

19294 Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy
(List separately in addition to code for primary procedure)

19296 Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy

19297 concurrent with partial mastectomy
(List separately in addition to primary procedure)
(Use 19297 in conjunction with code 19301 or 19302)

19298 Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance

MASTECTOMY PROCEDURES

19300 Mastectomy for gynecomastia

19301 Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);

19302 with axillary lymphadenectomy
19303 Mastectomy, simple, complete
19305 Mastectomy, radical, including pectoral muscles, axillary lymph nodes
19306 Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)
19307 Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

REPAIR AND/OR RECONSTRUCTION

(To report bilateral procedures, use modifier -50)

19316 Mastopexy (unilateral)
19318 Breast Reduction
19325 Breast augmentation with implant
19328 Removal of intact breast implant
19330 Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)
19340 Insertion of breast implant on same day of mastectomy (ie immediate)
19342 Insertion or replacement of breast implant on separate day from mastectomy
19350 Nipple/areola reconstruction
19355 Correction of inverted nipples
19357 Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361 Breast reconstruction; with latissimus dorsi flap
19364 with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)
19367 with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap
19368 with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)
19369 with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap
19370 Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371 Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380 Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
19396 Preparation of moulage for custom breast implant

OTHER PROCEDURES

19499 Unlisted procedure, breast

MUSCULOSKELETAL SYSTEM

Casts and strapping procedures appear at the end of this section.

The services listed below include the application and removal of the first cast or traction device only. Subsequent replacement of cast and/or traction device may require an additional listing.

DEFINITIONS:

The terms "closed treatment", "open treatment" and "percutaneous skeletal fixation" have been carefully chosen to accurately reflect current orthopedic procedural treatments.

CLOSED TREATMENT - specifically means that the fracture site is not surgically opened (exposed to the external environment and directly visualized). This terminology is used to describe procedures that treat fractures by three methods: 1) without manipulation; 2) with manipulation; or 3) with or without traction.

OPEN TREATMENT - is used when the fractured bone is either: 1) surgically opened (exposed to the external environment) and the fracture (bone ends) visualized and internal fixation may be used; or 2) the fractured bone is opened remote from the fracture site in order to insert an intramedullary nail across the fracture site (the fracture site is not opened and visualized).

PERCUTANEOUS SKELETAL FIXATION - describes fracture treatment which is neither open nor closed. In this procedure, the fracture fragments are not visualized, but fixation (eg, pins) is placed across the fracture site, usually under x-ray imaging.

The type of fracture (eg, open, compound, closed) does not have any coding correlation with the type of treatment (eg, closed, open or percutaneous) provided.

The codes for treatment of fractures and joint injuries (dislocations) are categorized by the type of manipulation (reduction) and stabilization (fixation or immobilization). These codes can apply to either open (compound) or closed fractures or joint injuries.

Skeletal traction is the application of a force (distracting or traction force) to a limb segment through a wire, pin, screw or clamp that is attached (eg, penetrates) to bone.

Skin traction is the application of a force (longitudinal) to a limb using felt or strapping applied directly to skin only.

External fixation is the usage of skeletal pins plus an attaching mechanism/device used for temporary or definitive treatment of acute or chronic bony deformity.

Codes for obtaining autogenous bone grafts, cartilage, tendon fascia lata grafts or other tissues, through separate incisions are to be used only when the graft is not already listed as part of the basic procedure.

Re-reduction of a fracture and/or dislocation performed by the primary physician may be identified by either the addition of the modifier -76 to the usual procedure number to indicate “Repeat Procedure by Same Physician.”

Codes for external fixation are to be used only when external fixation is not already listed as part of the basic procedure.

All codes for suction irrigation have been deleted. To report, list only the primary surgical procedure performed (eg, sequestrectomy, deep incision).

MANIPULATION - is used throughout the musculoskeletal fracture and dislocation subsections to specifically mean the attempted reduction or restoration of a fracture or joint dislocation to its normal anatomic alignment by the application of manually applied forces.

GENERAL

INCISION

WOUND EXPLORATION - TRAUMA (eg PENETRATING GUNSHOT, STAB WOUND)

20100-20103 relate to wound(s) resulting from penetrating trauma. These codes describe surgical exploration and enlargement of the wound, extension of dissection (to determine penetration), debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s), of the subcutaneous tissue, muscle fascia, and/or muscle, not requiring thoracotomy or laparotomy. If a repair is done to major structure(s) or major blood vessel(s) requiring thoracotomy or laparotomy, then those specific code(s) would supersede the use of codes 20100 - 20103. To report Simple, Intermediate or Complex repair of wound(s) that do not require enlargement of the wound, extension of dissection, etc., as stated above, use specific Repair code(s) in the Integumentary System section.

20100 Exploration of penetrating wound (separate procedure); neck
20101 chest
20102 abdomen/flank/back
20103 extremity

EXCISION

20150 Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision
20200 Biopsy, muscle; superficial
20205 deep
20206 Biopsy, muscle, percutaneous needle
20220 Biopsy, bone, trocar or needle; superficial (eg, ilium, sternum, spinous process, ribs)
20225 deep (eg, vertebral body, femur)
20240 Biopsy, bone, open; superficial (eg, sternum, spinous process, rib, patella, olecranon process, calcaneus tarsal, metatarsal, carpal, metacarpal, phalanx)
20245 deep (eg, humeral shaft, ischium, femoral shaft)
20250 Biopsy, vertebral body, open; thoracic
20251 lumbar or cervical

INTRODUCTION OR REMOVAL

20500 Injection of sinus tract; therapeutic (separate procedure)
20501 diagnostic (sinogram)
20520 Removal of foreign body in muscle, or tendon sheath, simple
20525 deep or complicated

20526 Injection, therapeutic (eg, local anesthetic; corticosteroid), carpal tunnel
20527 Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)
20550 Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")
20551 single tendon origin/insertion
20552 single or multiple trigger point(s), one or two muscle(s)
20553 single or multiple trigger point(s), three or more muscle(s)
20555 Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)
20600 Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance
20604 with ultrasound guidance, with permanent recording and reporting
20605 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, tempomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance
20606 with ultrasound guidance, with permanent recording and reporting
20610 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
20611 with ultrasound guidance, with permanent recording and reporting
20612 Aspiration and/or injection of ganglion cyst(s) any location
20615 Aspiration and injection for treatment of bone cyst
20650 Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)
20660 Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)
20661 Application of halo, including removal; cranial
20662 pelvic
20663 femoral
20664 Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta)
20665 Removal of tongs or halo applied by another individual
20670 Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)
20680 deep, (eg, buried wire, pin, screw, metal band, nail, rod or plate)
20690 Application of a uniplane (pins or wires in one plane), unilateral, external fixation system
20692 Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)
20693 Adjustment or revision of external fixation system requiring anesthesia (eg, new pin(s) or wire(s), and/or new ring(s) or bar(s))
20694 Removal, under anesthesia, of external fixation system

REPLANTATION

20802 Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation
20805 Replantation, forearm, (includes radius and ulna to radial carpal joint), complete amputation

20808 Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation
20816 Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation
20822 Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation
20824 Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputation
20827 Replantation, thumb (includes distal tip to MP joint), complete amputation
20838 Replantation, foot, complete amputation

GRAFTS (OR IMPLANTS)

Codes for obtaining autogenous bone, cartilage, tendon, fascia lata grafts, or other tissues through separate skin/fascial incisions should be reported separately unless the code descriptor references the harvesting of the graft or implant (eg, includes obtaining graft).

Do not append modifier –62 to bone graft codes 20900-20938.

20900 Bone graft, any donor area; minor or small (eg, dowel or button)
20902 major or large
20910 Cartilage graft; costochondral
20912 nasal septum
20920 Fascia lata graft; by stripper
20922 by incision and area exposure, complex or sheet
20924 Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)
20931 Allograft, structural, for spine surgery only
(List separately in addition to primary procedure)
20932 Allograft, includes templating, cutting, placement and internal fixation, when performed; osteoarticular including articular surface and contiguous bone (List separately in addition to primary procedure)
20933 hemicortical intercalary, partial (ie, hemicylindrical) (List separately in addition to primary procedure)
20934 intercalary, complete (ie, cylindrical) (List separately in addition to primary procedure)
20937 morselized (through separate skin or fascial incision)
(List separately in addition to primary procedure)
20938 structural, bicortical or tricortical (through separate skin or fascial incision)
(List separately in addition to code for primary procedure)
20939 Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in additional to code for primary procedure)

OTHER PROCEDURES

20950 Monitoring of interstitial fluid pressure (includes insertion of device eg, wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome
20955 Bone graft with microvascular anastomosis; fibula
20956 iliac crest
20957 metatarsal

20962 other than fibula, iliac crest, or metatarsal
20969 Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe
20970 iliac crest
20972 metatarsal
20973 great toe with web space
20974# Electrical stimulation to aid bone healing; noninvasive (nonoperative)
20975 invasive (operative)
20979# Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)
20982 Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency
20999 Unlisted procedure, musculoskeletal system, general

HEAD

Skull, facial bones and temporomandibular joint.

INCISION

21010 Arthrotomy, temporomandibular joint
(To report bilateral procedures, use modifier -50)

EXCISION

21011 Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm
21012 2 cm or greater
21013 Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm
21014 2 cm or greater
21015 Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm
21016 2 cm or greater
21025 Excision of bone (eg, for osteomyelitis or bone abscess); mandible
21026 facial bone(s)
21029 Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)
21030 Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage
21031 Excision of torus mandibularis
21032 Excision of maxillary torus palatinus
21034 Excision of malignant tumor of maxilla or zygoma
21040 Excision of benign tumor or cyst of mandible, by enucleation and/or curettage
21044 Excision of malignant tumor of mandible;
21045 radical resection
21046 Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))
21047 requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))

21048 Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))
21049 requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))
21050 Condylectomy, temporomandibular joint; (separate procedure)
(For bilateral procedures use modifier -50)
21060 Meniscectomy, partial or complete, temporomandibular joint (separate procedure)
(For bilateral procedures use modifier -50)
21070 Coronoidectomy (separate procedure)
(For bilateral procedures use modifier -50)

MANIPULATION

21073 Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)

HEAD PROSTHESIS

Codes 21076-21089 describe professional services for the rehabilitation of patients with oral, facial or other anatomical deficiencies by means of prostheses such as an artificial eye, ear or nose or intraoral obturator to close a cleft. Codes 21076-21089 should only be used when the physician actually designs and prepares the prosthesis (ie, not prepared by an outside laboratory).

21076 Impression and custom preparation; surgical obturator prosthesis
21077 orbital prosthesis
21079 interim obturator prosthesis
21080 definitive obturator prosthesis
21081 mandibular resection prosthesis
21082 palatal augmentation prosthesis
21083 palatal lift prosthesis
21084 speech aid prosthesis
21085 oral surgical splint
21086 auricular prosthesis
21087 nasal prosthesis
21088 facial prosthesis
21089 Unlisted maxillofacial prosthetic procedure

INTRODUCTION OR REMOVAL

21100 Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)
21110 Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21116 Injection procedure for temporomandibular joint arthrography

REPAIR, REVISION, AND/OR RECONSTRUCTION

21120 Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121 sliding osteotomy, single piece
21122 sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123 sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125 Augmentation, mandibular body or angle; prosthetic material
21127 with bone graft, onlay or interpositional (includes obtaining autograft)
21137 Reduction forehead; contouring only
21138 contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139 contouring and setback of anterior frontal sinus wall
21141 Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
21142 two pieces, segment movement in any direction, without bone graft
21143 three or more pieces, segment movement in any direction, without bone graft
21145 single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146 two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
21147 three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
21150 Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)
21151 any direction, requiring bone grafts (includes obtaining autografts)
21154 Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I
21155 with LeFort I
21159 Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160 with LeFort I
21172 Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175 Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179 Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180 with autograft (includes obtaining grafts)
21181 Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial
21182 Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm
21183 total area of bone grafting greater than 40 sq cm but less than 80 sq cm
21184 total area of bone grafting greater than 80 sq cm

21188 Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21193 Reconstruction of mandibular rami, horizontal, vertical, "C", or "L" osteotomy; without bone graft
21194 with bone graft (includes obtaining graft)
21195 Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196 with internal rigid fixation
21198 Osteotomy, mandible, segmental;
21199 with genioglossus advancement
21206 Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)
21208 Osteoplasty, facial bones; augmentation (autograft, allograft or prosthetic implant)
21209 reduction
21210 Graft, bone; nasal, maxillary and malar areas (includes obtaining graft)
21215 mandible (includes obtaining graft)
21230 Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235 ear cartilage, autograft, to nose or ear (includes obtaining graft)
21240 Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
21242 Arthroplasty, temporomandibular joint, with allograft
21243 Arthroplasty, temporomandibular joint, with prosthetic joint replacement
21244 Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
21245 Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246 complete
21247 Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
21248 Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
21249 complete
21255 Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256 Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)
21260 Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261 combined intra- and extracranial approach
21263 with forehead advancement
21267 Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268 combined intra- and extracranial approach
21270 Malar augmentation, prosthetic material
21275 Secondary revision of orbitocraniofacial reconstruction
21280 Medial canthopexy (separate procedure)
21282 Lateral canthopexy
21295 Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach
21296 intraoral approach

OTHER PROCEDURES

21299 Unlisted craniofacial and maxillofacial procedure

FRACTURE AND/OR DISLOCATION

21310 Closed treatment of nasal bone fracture without manipulation
21315 Closed treatment, nasal bone fracture; without stabilization
21320 with stabilization
21325 Open treatment of nasal fracture; uncomplicated
21330 complicated, with internal and/or external skeletal fixation
21335 with concomitant open treatment of fractured septum
21336 Open treatment of nasal septal fracture, with or without stabilization
21337 Closed treatment of nasal septal fracture, with or without stabilization
21338 Open treatment of nasoethmoid fracture; without external fixation
21339 with external fixation
21340 Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus
21343 Open treatment of depressed
21344 Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches
21345 Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint
21346 Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation
21347 requiring multiple open approaches
21348 with bone grafting (includes obtaining graft)
21355 Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation
21356 Open treatment of depressed zygomatic arch fracture (eg, Gilles approach)
21360 Open treatment of depressed malar fracture, including zygomatic arch and malar tripod
21365 Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches
21366 with bone grafting (includes obtaining graft)
21385 Open treatment of orbital floor blowout fracture; transantral approach (Caldwell Luc type operations)
21386 periorbital approach
21387 combined approach
21390 periorbital approach, with alloplastic or other implant
21395 periorbital approach with bone graft (includes obtaining graft)
21400 Closed treatment of fracture of orbit, except blowout; without manipulation
21401 with manipulation
21406 Open treatment of fracture of orbit except blowout; without implant
21407 with implant

21408 with bone grafting (includes obtaining graft)
21421 Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint
21422 Open treatment of palatal or maxillary fracture (LeFort I type);
21423 complicated (comminuted or involving cranial nerve foramina), multiple approaches
21431 Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint
21432 Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation
21433 complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches
21435 complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation)
21436 complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)
21440 Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21445 Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21450 Closed treatment of mandibular fracture; without manipulation
21451 with manipulation
21452 Percutaneous treatment of mandibular fracture, with external fixation
21453 Closed treatment of mandibular fracture with interdental fixation
21454 Open treatment of mandibular fracture with external fixation
21461 Open treatment of mandibular fracture; without interdental fixation
21462 with interdental fixation
21465 Open treatment of mandibular condylar fracture
21470 Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints
21480 Closed treatment of temporomandibular dislocation, initial or subsequent
21485 complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent
21490 Open treatment of temporomandibular dislocation

OTHER PROCEDURES

21497 Interdental wiring, for condition other than fracture
21499 Unlisted musculoskeletal procedure, head

NECK (SOFT TISSUES) AND THORAX

INCISION

21501 Incision and drainage, deep abscess or hematoma, soft tissues of neck of thorax;
21502 with partial rib ostectomy
21510 Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax

EXCISION

21550 Biopsy, soft tissue of neck or thorax

21552 Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater
21554 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater
21555 Excision tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm
21556 subfascial (eg, intramuscular); less than 5 cm
21557 Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm
21558 5 cm or greater
21600 Excision of rib, partial
21601 Excision of chest wall tumor including rib(s)
21602 Excision of chest wall tumor involving rib(s), with plastic reconstruction; without mediastinal lymphadenectomy
21603 with mediastinal lymphadenectomy
21610 Costotransversectomy (separate procedure)
21615 Excision first and/or cervical rib;
21616 with sympathectomy
21620 Ostectomy of sternum, partial
21627 Sternal debridement
21630 Radical resection of sternum;
21632 with mediastinal lymphadenectomy

REPAIR, REVISION AND/OR RECONSTRUCTION

21685 Hyoid myotomy and suspension
21700 Division of scalenus anticus; without resection of cervical rib
21705 with resection of cervical rib
21720 Division of sternocleidomastoid for torticollis, open operation; without cast application
21725 with cast application
21740 Reconstructive repair of pectus excavatum or carinatum; open
21742 minimally invasive approach (Nuss procedure), without thoracoscopy
21743 minimally invasive approach (Nuss procedure), with thoracoscopy
21750 Closure of median sternotomy separation with or without debridement (separate procedure)

FRACTURE AND/OR DISLOCATION

21811 Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs
21812 4-6 ribs
21813 7 or more ribs
21820 Closed treatment of sternum fracture
21825 Open treatment of sternum fracture with or without skeletal fixation

OTHER PROCEDURES

21899 Unlisted procedure, neck or thorax

BACK AND FLANK

EXCISION

21920 Biopsy, soft tissue of back or flank; superficial
21925 deep
21930 Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm
21931 3 cm or greater
21932 Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm
21933 5 cm or greater
21935 Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm
21936 5 cm or greater

SPINE (VERTEBRAL COLUMN)

Cervical, thoracic, and lumbar spine.

Within the SPINE section, bone grafting procedures are reported separately and in addition to arthrodesis. For bone grafts in other Musculoskeletal sections, see specific code(s) descriptor(s) and/or accompanying guidelines.

To report bone grafts performed after arthrodesis, see codes 20930-20938. Do not append modifier –62 to bone graft codes 20900 – 20938. Example: Posterior arthrodesis of L5-S1 for degenerative disc disease utilizing morselized autogenous iliac bone graft harvested through a separate fascial incision. Report as 22612 and 20937.

Within the SPINE section, instrumentation is reported separately and in addition to arthrodesis. To report instrumentation procedures performed with definitive vertebral procedure(s), see codes 22840-22855,22859. Instrumentation procedure codes 22840-22848,22853,22854,22859 are reported in addition to the definitive procedure(s). The modifier –62 may not be appended to the definitive add-on spinal instrumentation procedure code(s) 22840 – 22848, 22850,22852,22853,22854,22859.

Example:

Posterior arthrodesis of L4-S1, utilizing morselized autogenous iliac bone graft harvested through separate fascial incision, and pedicle screw fixation. Report as 22612, 22614, 22842 and 20937.

Vertebral procedures are sometimes followed by arthrodesis and in addition may include bone grafts and instrumentation. When arthrodesis is performed addition to another procedure, the arthrodesis should be reported in addition to the original procedure. Examples are after osteotomy, fracture care, vertebral corpectomy and laminectomy. Since bone grafts and instrumentation are never performed without arthrodesis, they are reported as add-on codes. Arthrodesis, however, may be performed in the absence of other procedures.

Example: Treatment of a burst fracture of L2 by corpectomy followed by arthrodesis of LI-L3, utilizing anterior instrumentation LI-L3 and structural allograft. Report as 63090, 22558-51, 22585, 22845 and 20931.

INCISION

22010 Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic
22015 lumbar, sacral, or lumbosacral
(Do not report 22015 in conjunction with 22010)
(Do not report 22015 in conjunction with instrumentation removal, 10180, 22850, 22852)

EXCISION

For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of partial vertebral body excision, each surgeon should report his/her distinct operative work by appending the modifier –62 to the procedure code. In this situation, the modifier –62 may be appended to the procedure code(s) 22100-22102, 22110-22114 and, as appropriate, to the associated additional vertebral segment add-on code(s) 22103, 22116 as long as both surgeons continue to work together as primary surgeons.

22100 Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical
22101 thoracic
22102 lumbar
22103 each additional segment
(List separately in addition to primary procedure)
(Use 22103 in conjunction with codes 22100, 22101, 22102)
22110 Partial excision of vertebral body for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical
22112 thoracic
22114 lumbar
22116 each additional vertebral segment
(List separately in addition to primary procedure)
(Use 22116 only for codes 22110, 22112, 22114)

OSTEOTOMY

For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of an anterior spine osteotomy, each surgeon should report his/her distinct operative work by appending the modifier –62 to the procedure code. In this situation, the modifier –62 may be appended to code(s) 22210-22214, 22220-22224 and, as appropriate, to associated additional segment add-on code(s) 22216, 22226 as long as both surgeons continue to work together as primary surgeons.

22206 Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic
(Do not report 22206 in conjunction with 22207)
22207 lumbar
(Do not report 22207 in conjunction with 22206)
22208 each additional vertebral segment
(List separately in addition to primary procedure)

(Use 22208 in conjunction with 22206, 22207)
(Do not report 22206, 22207, 22208 in conjunction with22210-22226, 22830, 63001-63048, 63055-63066, 63075-63091, 63101-63103, when performed at the same level)

22210 Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; cervical
22212 thoracic
22214 lumbar
22216 each additional segment
(List separately in addition to primary procedure)
(Use 22216 in conjunction with 22210, 22212, 22214)
22220 Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical
22222 thoracic
22224 lumbar
22226 each additional segment
(List separately in addition to primary procedure)
(Use 22226 only for codes 22220, 22222, 22224)

FRACTURE AND/OR DISLOCATION

For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of an open fracture and/or dislocation procedure(s), each surgeon should report his/her distinct operative work by appending the modifier –62 to the procedure code. In this situation, the modifier –62 may be appended to code(s) 22318-22327, and, as appropriate, to associated additional segment add-on code 22328 as long as both surgeons continue to work together as primary surgeons.

22310 Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing
22315 Closed treatment of vertebral fracture(s) and/or dislocation(s) requiring casting or bracing, with and including casting and/or bracing by manipulation or traction
22318 Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) including os odontoideum), anterior approach, including placement of internal fixation; without grafting
22319 with grafting
22325 Open treatment and/or reduction of vertebral fracture (s) and/or dislocation(s); posterior approach, one fractured vertebrae or dislocated segment; lumbar
22326 cervical
22327 thoracic
22328 each additional fractured vertebrae or dislocated segment
(List separately in addition to primary procedure)
(Use 22328 in conjunction with codes 22325, 22326, 22327)

MANIPULATION

22505 Manipulation of spine requiring anesthesia, any region

PERCUTANEOUS VEREBROPLASTY and VERTEBRAL AUGMENTATION

22510 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
22511 lumbosacral
22512 each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)
22513 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic
22514 lumbar
22515 each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

VERTEBRAL BODY, EMBOLIZATION OR INJECTION

22526 Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level
22527 one or more additional levels (List separately in addition primary procedure)
(Do not report codes 22526, 22527 in conjunction with 77002, 77003)

ARTHRODESIS

LATERAL EXTRACAVITARY APPROACH TECHNIQUE

22532 Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic
22533 lumbar
22534 thoracic or lumbar, each additional vertebral segment (List separately in addition to primary procedure)
(Use 22534 in conjunction with 22532 and 22533)

ANTERIOR OR ANTEROLATERAL APPROACH TECHNIQUE

Procedure codes 22554-22558 are for SINGLE interspace; for additional interspaces, use 22585. A vertebral interspace is the non-bony compartment between two adjacent vertebral bodies, which contains the intervertebral disc, and includes the nucleus pulposus, annulus fibrosus, and two cartilagenous endplates.

For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of an anterior interbody arthrodesis, each surgeon should report his/her distinct operative work by appending the modifier –62 to the procedure code.

In this situation, the modifier –62 may be appended to the procedure code(s) 22548-22558 and, as appropriate, to the associated additional interspace add-on code 22585 as long as both surgeons continue to work together as primary surgeons.

22548 Arthrodesis, anterior transoral or extraoral technique, clivus-Cl-C2 (atlas-axis), with or without excision of odontoid process
22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552 cervical below C2, each additional interspace
(List separately in addition to primary procedure)
22554 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
22556 thoracic
22558 lumbar
22585 each additional interspace
(List separately in addition to primary procedure)
(Use 22585 in conjunction with 22554, 22556, 22558)
22586 Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace

POSTERIOR, POSTEROLATERAL OR LATERAL TRANSVERSE PROCESS TECHNIQUE

A vertebral segment describes the basic constituent part into which the spine may be divided. It represents a single complete vertebral bone with its associated articular processes and laminae. A vertebral interspace is the non-bony compartment between two adjacent vertebral bodies which contains the intervertebral disk, and includes the nucleus pulposus, annulus fibrosus, and two cartilagenous endplates.

22590 Arthrodesis, posterior technique, craniocervical (occiput-C2)
22595 Arthrodesis, posterior technique, atlas-axis (Cl-C2)
22600 Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment
22610 thoracic (with lateral transverse technique, when performed)
22612 lumbar (with lateral transverse technique, when performed)
22614 each additional vertebral segment
(List separately in addition to primary procedure)
(Use 22614 in conjunction with 22600, 22610, 22612)
22630 Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression) single interspace; lumbar
22632 each additional interspace
(List separately in addition to primary procedure)
(Use 22632 in conjunction with 22630)

22633 Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar
22634 each additional interspace and segment
(List separately in addition to primary procedure)
(Use 22634 in conjunction with 22633)

SPINE DEFORMITY (EG, SCOLIOSIS, KYPHOSIS)

A vertebral segment describes the basic constituent part into which the spine may be divided. It represents a single complete vertebral bone with its associated articular processes and laminae.

For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of an arthrodesis for spinal deformity, each surgeon should report his/her distinct operative work by appending the modifier –62 to the procedure code. In this situation, the modifier –62 may be appended to the procedure code(s) 22800-22819 as long as both surgeons continue to work together as primary surgeons.

22800 Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments
22802 7 to 12 vertebral segments
22804 13 or more vertebral segments
22808 Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments
22810 4 to 7 vertebral segments
22812 8 or more vertebral segments
22818 Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments
22819 3 or more segments

EXPLORATION

22830 Exploration of spinal fusion

SPINAL INSTRUMENTATION

Segmental instrumentation is defined as fixation at each end of the construct and at least one additional interposed bony attachment.

Non segmental instrumentation is defined as fixation at each end of the construct and may span several vertebral segments without attachment to the intervening segments.

Insertion of spinal instrumentation is reported separately and in addition to arthrodesis. Instrumentation procedure codes 22840-22848

are reported in addition to the definitive procedure(s). Do not append modifier –62 to spinal instrumentation codes 22840-22848 and 22850-22852.

To report bone graft procedures, see codes 20931-20938. (Report in addition to code(s) for definitive procedure(s).) Do not append modifier –62 to bone graft codes 20900-20938.

A vertebral segment describes the basic constituent part into which the spine may be divided. It represents a single complete vertebral bone with its associated articular processes and laminae. A vertebral interspace is the non-bony compartment between two adjacent vertebral bodies, which contains the intervertebral disk, and includes the nucleus pulposus, annulus fibrosus, and two cartilagenous endplates.

List 22840-22855 separately, in conjunction with code(s) for fracture, dislocation, arthrodesis or exploration of fusion of the spine 22325-22328, 22532-22534, 22548-22812, and 22830.

Codes 22840-22848, are reported in conjunction with code(s) for the definitive procedure(s). Code 22849 should not be reported with 22850, 22852, and 22855 at the same spinal levels.

22840 Posterior non-segmental instrumentation (eg, Harrington Rod Technique), pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation
(List separately in addition to primary procedure)

22842 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments
(List separately in addition to primary procedure)

22843 7 to 12 vertebral segments
(List separately in addition to primary procedure)

22844 13 or more vertebral segments

22845 Anterior instrumentation; 2 to 3 vertebral segments
(List separately in addition to primary procedure)

22846 4 to 7 vertebral segments

22847 8 or more vertebral segments

22848 Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum
(List separately in addition to primary procedure)

22849 Reinsertion of spinal fixation device

22850 Removal of posterior nonsegmental instrumentation (eg, Harrington rod)

22852 Removal of posterior segmental instrumentation

22853 Insertion of interbody biomechanical device(s) (eg,synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)

22854 Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial of complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)

22859 Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate), to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)

22855 Removal of anterior instrumentation
22856 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical
22858 second level,cervical (List separately in addition to code for primary procedure)

22857 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar
22861 Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22862 lumbar

22864 Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
(Do not report 22864 in conjunction with 22861)
22865 Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace, lumbar

OTHER PROCEDURES

22899 Unlisted procedure, spine

ABDOMEN

EXCISION

22900 Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm
22901 5 cm or greater
22902 Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm
22903 3 cm or greater
22904 Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; less than 5 cm
22905 5 cm or greater

OTHER PROCEDURES

22999 Unlisted procedure, abdomen, musculoskeletal system

SHOULDER

Clavicle, scapula, humerus head and neck, sternoclavicular joint, acromioclavicular joint and shoulder joint.

INCISION

23000 Removal of subdeltoid calcareous deposits, open
23020 Capsular contracture release (eg, Sever type procedure)
23030 Incision and drainage, shoulder area; deep abscess or hematoma

23031 infected bursa
23035 Incision, bone cortex (eg, osteomyelitis or bone abscess), shoulder area
23040 Arthrotomy, glenohumeral joint, including exploration, drainage or removal of foreign body
23044 Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage or removal of foreign body

EXCISION

23065 Biopsy, soft tissues; superficial
23066 deep
23071 Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater
23073 Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greater
23075 Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm
23076 Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm
23077 Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; less than 5 cm
23078 5 cm or greater
23100 Arthrotomy, glenohumeral joint, including biopsy
23101 Arthrotomy, acromioclavicular joint or sternoclavicular joint, including biopsy and/or excision of torn cartilage
23105 Arthrotomy, glenohumeral joint with synovectomy, with or without biopsy
23106 sternoclavicular joint, with synovectomy, with or without biopsy
23107 Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body
23120 Claviculectomy; partial
23125 total
23130 Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release
23140 Excision or curettage of bone cyst or benign tumor of clavicle or scapula;
23145 with autograft (includes obtaining graft)
23146 with allograft
23150 Excision or curettage of bone cyst or benign tumor of proximal humerus;
23155 with autograft (includes obtaining graft)
23156 with allograft
23170 Sequestrectomy (eg, for osteomyelitis or bone abscess); clavicle
23172 scapula
23174 humeral head to surgical neck
23180 Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); clavicle
23182 scapula
23184 proximal humerus
23190 Ostectomy of scapula, partial (eg, superior medial angle)
23195 Resection humeral head
23200 Radical resection of tumor; clavicle
23210 scapula
23220 Radical resection of tumor, proximal humerus

INTRODUCTION OR REMOVAL

23330 Removal of foreign body, shoulder; subcutaneous
23333 deep (subfascial or intramuscular)
23334 Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component
23335 humeral and glenoid components (eg, total shoulder)
23350 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

REPAIR, REVISION AND/OR RECONSTRUCTION

23395 Muscle transfer, any type, shoulder or upper arm; single
23397 multiple
23400 Scapulopexy (eg, Sprengels deformity or for paralysis)
23405 Tenotomy, shoulder area; single tendon
23406 multiple tendons through same incision
23410 Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute
23412 chronic
23415 Coracoacromial ligament release, with or without acromioplasty
23420 Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)
23430 Tenodesis of long tendon of biceps
23440 Resection or transplantation of long tendon of biceps
23450 Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation
23455 with labral repair (eg, Bankart procedure)
23460 Capsulorrhaphy, anterior, any type; with bone block
23462 with coracoid process transfer
23465 Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block
23466 Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
23470 Arthroplasty, glenohumeral joint; hemiarthroplasty
23472 total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)
23473 Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component
23474 humeral and glenoid component
23480 Osteotomy, clavicle, with or without internal fixation;
23485 with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)
23490 Prophylactic treatment (nailing, pinning, plating, or wiring) with or without methylmethacrylate; clavicle
23491 proximal humerus

FRACTURE AND/OR DISLOCATION

23500 Closed treatment of clavicular fracture; without manipulation
23505 with manipulation
23515 Open treatment of clavicular fracture, includes internal fixation, when performed

23520 Closed treatment of sternoclavicular dislocation; without manipulation
23525 with manipulation
23530 Open treatment of sternoclavicular dislocation, acute or chronic;
23532 with fascial graft (includes obtaining graft)
23540 Closed treatment of acromioclavicular dislocation; without manipulation
23545 with manipulation
23550 Open treatment of acromioclavicular dislocation, acute or chronic;
23552 with fascial graft (includes obtaining graft)
23570 Closed treatment of scapular fracture; without manipulation
23575 with manipulation, with or without skeletal traction (with or without shoulder joint involvement)
23585 Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation, when performed
23600 Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation
23605 with manipulation, with or without skeletal traction
23615 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed;
23616 with proximal humeral prosthetic replacement
23620 Closed treatment of greater humeral tuberosity fracture; without manipulation
23625 with manipulation
23630 Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed
23650 Closed treatment of shoulder dislocation, with manipulation; without anesthesia
23655 requiring anesthesia
23660 Open treatment of acute shoulder dislocation
23665 Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation
23670 Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed
23675 Closed treatment of shoulder dislocation, with surgical or anatomical neck fracture, with manipulation
23680 Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed

MANIPULATION

23700 Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded)

ARTHRODESIS

23800 Arthrodesis, glenohumeral joint;
23802 with autogenous graft (includes obtaining graft)

AMPUTATION

23900 Interthoracoscapular amputation (forequarter)
23920 Disarticulation of shoulder;
23921 secondary closure or scar revision

OTHER PROCEDURES

23929 Unlisted procedure, shoulder

HUMERUS (UPPER ARM) AND ELBOW

Elbow area includes head and neck of radius and olecranon process.

INCISION

23930 Incision and drainage upper arm or elbow area; deep abscess or hematoma
23931 bursa
23935 Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), humerus or elbow
24000 Arthrotomy, elbow, including exploration, drainage or removal of foreign body
24006 Arthrotomy of the elbow, with capsular excision for capsular release (separate procedure)

EXCISION

24065 Biopsy, soft tissue of upper arm or elbow area; superficial
24066 deep (subfascial or intramuscular)
24071 Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater
24073 Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater
24075 Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm
24076 Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm
24077 Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; less than 5 cm
24079 5 cm or greater
24100 Arthrotomy, elbow; with synovial biopsy only
24101 with joint exploration, with or without biopsy, with or without removal of loose or foreign body
24102 with synovectomy
24105 Excision, olecranon bursa
24110 Excision or curettage of bone cyst or benign tumor, humerus;
24115 with autograft (includes obtaining graft)
24116 with allograft
24120 Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process;

24125 with autograft (includes obtaining graft)
24126 with allograft
24130 Excision, radial head
24134 Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus
24136 radial head or neck
24138 olecranon process
24140 Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis); humerus
24145 radial head or neck
24147 olecranon process
24149 Radical resection of capsule, soft tissue, and heterotopic bone, elbow, with contracture release (separate procedure)
24150 Radical resection of tumor, shaft or distal humerus
24152 Radical resection of tumor, radial head or neck
24155 Resection of elbow joint (arthrectomy)

INTRODUCTION OR REMOVAL

24160 Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components
24164 radial head
24200 Removal of foreign body, upper arm or elbow area; subcutaneous
24201 deep (subfascial or intramuscular)
24220 Injection procedure for elbow arthrography

REPAIR, REVISION AND/OR RECONSTRUCTION

24300 Manipulation, elbow, under anesthesia
24301 Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)
24305 Tendon lengthening, upper arm or elbow, each tendon
24310 Tenotomy, open, elbow to shoulder, each tendon
24320 Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)
24330 Flexor-plasty, elbow, (eg, Steindler type advancement);
24331 with extensor advancement
24332 Tenolysis, triceps
24340 Tenodesis of biceps tendon at elbow (separate procedure)
24341 Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)
24342 Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
24343 Repair lateral collateral ligament, elbow, with local tissue
24344 Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24345 Repair medial collateral ligament, elbow, with local tissue

24346 Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24357 Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous
24358 Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open
24359 Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment
24360 Arthroplasty, elbow; with membrane (eg, fascial)
24361 with distal humeral prosthetic replacement
24362 with implant and fascia lata ligament reconstruction
24363 with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)
24365 Arthroplasty, radial head;
24366 with implant
24370 Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component
24371 humeral and ulnar component
24400 Osteotomy, humerus, with or without internal fixation
24410 Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)
24420 Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876)
24430 Repair of nonunion or malunion, humerus; without graft (eg, compression technique, etc)
24435 with iliac or other autograft (includes obtaining graft)
24470 Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus)
24495 Decompression fasciotomy, forearm, with brachial artery exploration
24498 Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, humeral shaft

FRACTURE AND/OR DISLOCATION

24500 Closed treatment of humeral shaft fracture; without manipulation
24505 with manipulation, with or without skeletal traction
24515 Open treatment of humeral shaft fracture with plate/screws, with or without cerclage
24516 Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws
24530 Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; without manipulation
24535 with manipulation, with or without skin or skeletal traction
24538 Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension
24545 Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension
24546 with intercondylar extension
24560 Closed treatment of humeral epicondylar fracture, medial or lateral; without manipulation
24565 with manipulation

24566 Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation
24575 Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed
24576 Closed treatment of humeral condylar fracture, medial or lateral; without manipulation
24577 with manipulation
24579 Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed
24582 Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation
24586 Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius);
24587 with implant arthroplasty
(See also 24361)
24600 Treatment of closed elbow dislocation; without anesthesia
24605 requiring anesthesia
24615 Open treatment of acute or chronic elbow dislocation
24620 Closed treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with manipulation
24635 Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed
24640 Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation
24650 Closed treatment of radial head or neck fracture; without manipulation
24655 with manipulation
24665 Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed;
24666 with radial head prosthetic replacement
24670 Closed treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process [es]); without manipulation
24675 with manipulation
24685 Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process [es]), includes internal fixation, when performed

ARTHRODESIS

24800 Arthrodesis, elbow joint; local
24802 with autogenous graft (includes obtaining graft)

AMPUTATION

24900 Amputation, arm through humerus; with primary closure
24920 open, circular (guillotine)
24925 secondary closure or scar revision
24930 re-amputation
24931 with implant

24935 Stump elongation, upper extremity
24940 Cineplasty, upper extremity, complete procedure

OTHER PROCEDURES

24999 Unlisted procedure, humerus or elbow

FOREARM AND WRIST

Radius, ulna, carpal bones and joints.

INCISION

25000 Incision, extensor tendon sheath, wrist (eg, deQuervains disease)
25001 Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)
25020 Decompression fasciotomy, forearm and/or wrist, flexor or extensor compartment; without debridement of nonviable muscle and/or nerve
25023 with debridement of nonviable muscle and/or nerve
25024 Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve
25025 with debridement of nonviable muscle and/or nerve
25028 Incision and drainage forearm and/or wrist; deep abscess or hematoma
25031 bursa
25035 Incision, deep, bone cortex, forearm and/or wrist (eg, for osteomyelitis or bone abscess)
25040 Arthrotomy, radiocarpal or midcarpal joint, with exploration, drainage, or removal of foreign body

EXCISION

25065 Biopsy, soft tissue; superficial
25066 deep (subfascial or intramuscular)
25071 Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater
25073 Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater
25075 Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm
25076 Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm
25077 Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; less than 3 cm
25078 3 cm or greater
25085 Capsulotomy, wrist (eg, for contracture)
25100 Arthrotomy, wrist joint; with biopsy
25101 with joint exploration, with or without biopsy, with or without removal of loose or foreign body
25105 with synovectomy
25107 Arthrotomy, distal radioulnar joint including repair of triangular cartilage, complex

25109 Excision of tendon, forearm and/or wrist, flexor or extensor, each
25110 Excision, lesion of tendon sheath
25111 Excision of ganglion, wrist (dorsal or volar); primary
25112 recurrent
25115 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors
25116 extensors (with or without transposition of dorsal retinaculum)
25118 Synovectomy, extensor tendon sheath, wrist, single compartment;
25119 with resection of distal ulna
25120 Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process);
25125 with autograft (includes obtaining graft)
25126 with allograft
25130 Excision or curettage of bone cyst or benign tumor of carpal bones;
25135 with autograft (includes obtaining graft)
25136 with allograft
25145 Sequestrectomy (eg, for osteomyelitis or bone abscess)
25150 Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis); ulna
25151 radius
25170 Radical resection for tumor, radius or ulna
25210 Carpectomy; one bone
25215 all bones of proximal row
25230 Radial styloidectomy (separate procedure)
25240 Excision distal ulna partial or complete (eg, Darrach type or matched resection)

INTRODUCTION OR REMOVAL

25246 Injection procedure for wrist arthrography
25248 Exploration with removal of deep foreign body, forearm or wrist
25250 Removal of wrist prosthesis; (separate procedure)
25251 complicated, including total wrist
25259 Manipulation, wrist, under anesthesia

REPAIR, REVISION AND/OR RECONSTRUCTION

25260 Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle
25263 secondary, single, each tendon or muscle
25265 secondary, with free graft (includes obtaining graft) each tendon or muscle
25270 Repair, tendon or muscle, extensor; forearm and/or wrist; primary, single, each tendon or muscle
25272 secondary, single, each tendon or muscle
25274 secondary, with free graft (includes obtaining graft), each tendon or muscle

25275 Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for exterior carpi ulnaris subluxation)
25280 Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist; single, each tendon
25290 Tenotomy, open, flexor or extensor tendon, forearm and/or wrist single, each tendon
25295 Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon
25300 Tenodesis at wrist; flexors of fingers
25301 extensors of fingers
25310 Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon
25312 with tendon graft(s) (includes obtaining graft), each tendon
25315 Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist;
25316 with tendon(s) transfer
25320 Capsulorrhaphy or reconstruction, wrist, open, (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability
25332 Arthroplasty, wrist, with or without interposition, with or without external or internal fixation
25335 Centralization of wrist on ulna (eg, radial club hand)
25337 Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by soft tissue stabilization (eg, tendon transfer, tendon graft or weave, or tenodesis) with or without open reduction of distal radioulnar joint
25350 Osteotomy, radius; distal third
25355 middle or proximal third
25360 Osteotomy; ulna
25365 radius AND ulna
25370 Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna
25375 radius AND ulna
25390 Osteoplasty, radius OR ulna; shortening
25391 lengthening with autograft
25392 Osteoplasty, radius AND ulna; shortening (excluding 64876)
25393 lengthening with autograft
25394 Osteoplasty, carpal bone, shortening
25400 Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)
25405 with autograft (includes obtaining graft)
25415 Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)
25420 with autograft (includes obtaining graft)
25425 Repair of defect with autograft; radius OR ulna
25426 radius AND ulna
25430 Insertion of vascular pedicle into carpal bone (eg, Hori procedure)
25431 Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone
25440 Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)
25441 Arthroplasty with prosthetic replacement; distal radius

25442 distal ulna
25443 scaphoid carpal (navicular)
25444 lunate
25445 trapezium
25446 distal radius and partial or entire carpus ("total wrist")
25447 Arthroplasty interposition, intercarpal or carpometacarpal joints
25449 Revision of arthroplasty, including removal of implant, wrist joint
25450 Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna
25455 distal radius AND ulna
25490 Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius
25491 ulna
25492 radius AND ulna

FRACTURE AND/OR DISLOCATION

25500 Closed treatment of radial shaft fracture; without manipulation
25505 with manipulation
25515 Open treatment of radial shaft fracture, includes internal fixation, when performed
25520 Closed treatment of radial shaft fracture and closed treatment of dislocation of distal radio-ulnar joint (Galeazzi fracture/dislocation)
25525 Open treatment of radial shaft fracture, includes internal fixation, when performed, and closed treatment of distal radioulnar joint dislocation (Galeazzi fracture/dislocation), includes percutaneous skeletal fixation, when performed
25526 Open treatment of radial shaft fracture, includes internal fixation, when performed, and open treatment of distal radioulnar joint dislocation (Galeazzi fracture/dislocation), includes internal fixation, when performed, includes repair of triangular fibrocartilage complex
25530 Closed treatment of ulnar shaft fracture; without manipulation
25535 with manipulation
25545 Open treatment of ulnar shaft fracture, includes internal fixation, when performed
25560 Closed treatment of radial and ulnar shaft fractures; without manipulation
25565 with manipulation
25574 Open treatment of radial and ulnar shaft fractures, with internal fixation, when performed; of radius or ulna
25575 of radius and ulna
25600 Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; without manipulation
25605 with manipulation
25606 Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation
25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation
25608 with internal fixation of 2 fragments
(Do not report 25608 in conjunction with 25609)
25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments

25622 Closed treatment of carpal scaphoid (navicular) fracture; without manipulation
25624 with manipulation
25628 Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed
25630 Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); without manipulation, each bone
25635 with manipulation, each bone
25645 Open treatment of carpal bone fracture (other than carpal scaphoid (navicular)), each bone
25650 Closed treatment of ulnar styloid fracture
(Do not report 25650 in conjunction with 25600, 25605, 25607-25609)
25651 Percutaneous skeletal fixation of ulnar styloid fracture
25652 Open treatment of ulnar styloid fracture
25660 Closed treatment of radiocarpal or intercarpal dislocation, one or more bones, with manipulation
25670 Open treatment of radiocarpal or intercarpal dislocation, one or more bones
25671 Percutaneous skeletal fixation of distal radioulnar dislocation
25675 Closed treatment of distal radioulnar dislocation with manipulation
25676 Open treatment of distal radioulnar dislocation, acute or chronic
25680 Closed treatment of trans-scaphoperilunar type of fracture dislocation, with manipulation
25685 Open treatment of trans-scaphoperilunar type of fracture dislocation
25690 Closed treatment of lunate dislocation, with manipulation
25695 Open treatment of lunate dislocation

ARTHRODESIS

25800 Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)
25805 with sliding graft
25810 with iliac or other autograft (includes obtaining graft)
25820 Arthrodesis, wrist; limited, without bone graft (eg, intercarpal or radiocarpal)
25825 with autograft (includes obtaining graft)
25830 Arthrodesis with distal radioulnar joint and segmental resection of ulna, with or without bone graft (eg, Sauve-Kapandji procedure)

AMPUTATION

25900 Amputation, forearm, through radius and ulna;
25905 open, circular (guillotine)
25907 secondary closure or scar revision
25909 re-amputation
25915 Krukenberg procedure
25920 Disarticulation through wrist;
25922 secondary closure or scar revision
25924 re-amputation
25927 Transmetacarpal amputation;
25929 secondary closure or scar revision

25931 re-amputation

OTHER PROCEDURES

25999 Unlisted procedure, forearm or wrist

HAND AND FINGERS

INCISION

26010 Drainage of finger abscess; simple
26011 complicated (eg, felon)
26020 Drainage of tendon sheath, one digit and/or palm, each
26025 Drainage of palmar bursa; single bursa
26030 multiple bursa
26034 Incision, bone cortex, hand or finger (eg, osteomyelitis or bone abscess)
26035 Decompression fingers and/or hand, injection injury (eg, grease gun)
26037 Decompressive fasciotomy, hand (excludes 26035)
26040 Fasciotomy, palmar, (eg, Dupuytren's contracture); percutaneous
26045 open, partial
26055 Tendon sheath incision (eg, for trigger finger)
26060 Tenotomy, percutaneous, single, each digit
26070 Arthrotomy, with exploration, drainage, or removal of foreign body; carpometacarpal joint
26075 metacarpophalangeal joint, each
26080 interphalangeal joint, each

EXCISION

26100 Arthrotomy with biopsy; carpometacarpal joint, each
26105 metacarpophalangeal joint, each
26110 interphalangeal joint, each
26111 Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater
26113 Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater
26115 Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm
26116 Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm
26117 Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; less than 3 cm
26118 3 cm or greater
26121 Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)
26123 Fasciectomy, partial palmar with release, of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft);
26125 each additional digit

(List separately in addition to primary procedure)
(Use 26125 in conjunction with code 26123)
26130 Synovectomy, carpometacarpal joint
26135 Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit
26140 Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint
26145 Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon
26160 Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger
26170 Excision of tendon, palm, flexor, or extensor, single, each tendon
(Do not report 26170 in conjunction with 26390, 26415)
26180 Excision of tendon, finger, flexor or extensor, each tendon
(Do not report 26180 in conjunction with 26390, 26415)
26185 Sesamoidectomy, thumb or finger (separate procedure)
26200 Excision or curettage of bone cyst or benign tumor of metacarpal;
26205 with autograft (includes obtaining graft)
26210 Excision or curettage of bone cyst or benign tumor of proximal, middle or distal phalanx;
26215 with autograft (includes obtaining graft)
26230 Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, for osteomyelitis); metacarpal
26235 proximal or middle phalanx
26236 distal phalanx
26250 Radical resection metacarpal; (eg, tumor)
26260 Radical resection, proximal or middle phalanx of finger (eg, tumor);
26262 Radical resection, distal phalanx of finger (eg, tumor)

INTRODUCTION OR REMOVAL

26320 Removal of implant from finger or hand

REPAIR, REVISION AND/OR RECONSTRUCTION

26340 Manipulation, finger joint, under anesthesia, each joint
26341 Manipulation, palmar fascial cord (ie, Dupuytren’s cord), post enzyme injection (eg, collagenase), single cord
26350 Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon
26352 secondary with free graft (includes obtaining graft), each tendon
26356 Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon
26357 secondary, without free graft, each tendon
26358 secondary with free graft (includes obtaining graft), each tendon
26370 Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon

26372 secondary with free graft (includes obtaining graft), each tendon
26373 secondary without free graft, each tendon
26390 Excision flexor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod
26392 Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod
26410 Repair, extensor tendon, primary or secondary; without free graft, each tendon
26412 with free graft (includes obtaining graft), each tendon
26415 Excision of extensor tendon, implantation of synthetic rod for delayed tendon graft, hand or finger, each rod
26416 Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod
26418 Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon
26420 with free graft (includes obtaining each tendon graft)
26426 Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); using local tissue(s), including lateral band(s), each finger
26428 with free graft (includes obtaining graft), each finger
26432 Closed treatment of distal extensor tendon insertion, with or without percutaneous pinning (eg, mallet finger)
26433 Repair extensor tendon, distal insertion, primary or secondary; without graft (eg, mallet finger)
26434 with free graft (includes obtaining graft)
26437 Realignment of extensor tendon, hand, each tendon
26440 Tenolysis, flexor tendon; palm OR finger, each tendon
26442 palm AND finger, each tendon
26445 Tenolysis, extensor tendon, hand or finger; each tendon
26449 Tenolysis, complex, extensor tendon, finger, including forearm, each tendon
26450 Tenotomy, flexor, palm, open, each tendon
26455 Tenotomy, flexor, finger, open, each tendon
26460 Tenotomy, extensor, hand or finger, open, each tendon
26471 Tenodesis; of proximal interphalangeal joint, each joint
26474 of distal joint, each joint
26476 Lengthening of tendon, extensor, hand or finger, each tendon
26477 Shortening of tendon, extensor, hand or finger, each tendon
26478 Lengthening of tendon, flexor, hand or finger, each tendon
26479 Shortening of tendon, flexor, hand or finger, each tendon
26480 Transfer or transplant of tendon, carpometacarpal area or dorsum of hand, without free graft, each tendon
26483 with free tendon graft (includes obtaining graft), each tendon
26485 Transfer or transplant of tendon, palmar; without free tendon graft, each tendon
26489 with free tendon graft (includes obtaining graft), each tendon
26490 Opponensplasty; superficialis tendon transfer type, each tendon
26492 tendon transfer with graft (includes obtaining graft), each tendon
26494 hypothenar muscle transfer
26496 other methods

26497 Transfer of tendon to restore intrinsic function; ring and small finger
26498 all four fingers
26499 Correction claw finger, other methods
26500 Reconstruction of tendon pulley, each tendon; with local tissues (separate procedure)
26502 with tendon or fascial graft (includes obtaining graft) (separate procedure)
26508 Release of thenar muscle(s) (eg, thumb contracture)
26510 Cross intrinsic transfer, each tendon
26516 Capsulodesis, metacarpophalangeal joint; single digit
26517 two digits
26518 three or four digits
26520 Capsulectomy or capsulotomy; metacarpophalangeal joint, each joint
26525 interphalangeal joint, each joint
26530 Arthroplasty, metacarpophalangeal joint; each joint
26531 with prosthetic implant, each joint
26535 Arthroplasty interphalangeal joint; each joint
26536 with prosthetic implant, each joint
26540 Repair of collateral ligament, metacarpophalangeal or interphalangeal joint
26541 Reconstruction, collateral ligament, metacarpophalangeal joint, single, with tendon or fascial graft (includes obtaining graft)
26542 with local tissue (eg, adductor advancement)
26545 Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint
26546 Repair non-union, metacarpal or phalanx, (includes obtaining bone graft with or without external or internal fixation)
26548 Repair and reconstruction, finger, volar plate, interphalangeal joint
26550 Pollicization of a digit
26551 Transfer, toe-to-hand with microvascular anastomosis; great toe wrap around with bone graft
26553 other than great toe, single
26554 other than great toe, double
26555 Transfer, finger to another position without microvascular anastomosis
26556 Transfer, free toe joint, with microvascular anastomosis
26560 Repair of syndactyly (web finger), each web space; with skin flaps
26561 with skin flaps and grafts
26562 complex (eg, involving bone, nails)
26565 Osteotomy; metacarpal, each
26567 phalanx of finger, each
26568 Osteoplasty, lengthening, metacarpal or phalanx
26580 Repair cleft hand
26587 Reconstruction of polydactylous digit, soft tissue and bone
26590 Repair macrodactylia, each digit
26591 Repair, intrinsic muscles of hand, each muscle
26593 Release, intrinsic muscles of hand, each muscle
26596 Excision of constricting ring of finger, with multiple Z-plasties

FRACTURE AND/OR DISLOCATION

26600 Closed treatment of metacarpal fracture, single; without manipulation, each bone

26605 with manipulation, each bone
26607 Closed treatment of metacarpal fracture, with manipulation, with external fixation, each bone
26608 Percutaneous skeletal fixation of metacarpal fracture, each bone
26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone
26641 Closed treatment of carpometacarpal dislocation, thumb, with manipulation
26645 Closed treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation
26650 Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation
26665 Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed
26670 Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; without anesthesia
26675 requiring anesthesia
26676 Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb, with manipulation, each joint
26685 Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint
26686 complex, multiple or delayed reduction
26700 Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia
26705 requiring anesthesia
26706 Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation
26715 Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed
26720 Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each
26725 with manipulation, with or without skin or skeletal traction, each
26727 Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each
26735 Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each
26740 Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; without manipulation, each
26742 with manipulation, each
26746 Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each
26750 Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each
26755 with manipulation, each
26756 Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each
26765 Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each
26770 Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia

26775 requiring anesthesia
26776 Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation
26785 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single

ARTHRODESIS

26820 Fusion in opposition, thumb, with autogenous graft (includes obtaining graft)
26841 Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation;
26842 with autograft (includes obtaining graft)
26843 Arthrodesis, carpometacarpal joint, digit, other than thumb, each;
26844 with autograft (includes obtaining graft)
26850 Arthrodesis, metacarpophalangeal joint, with or without internal fixation;
26852 with autograft (includes obtaining graft)
26860 Arthrodesis, interphalangeal joint, with or without internal fixation;
26861 each additional interphalangeal joint
(List separately in addition to primary procedure)
(Use 26861 in conjunction with 26860)
26862 with autograft (includes obtaining graft)
26863 with autograft (includes obtaining graft), each additional joint
(List separately in addition to primary procedure)
(Use 26863 in conjunction with 26862)

AMPUTATION

26910 Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseous transfer
26951 Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure
26952 with local advancement flap (V-Y, hood)

OTHER PROCEDURES

26989 Unlisted procedure, hands or fingers

PELVIS AND HIP JOINT

Including head and neck of femur.

INCISION

26990 Incision and drainage; pelvis or hip joint area; deep abscess or hematoma
26991 infected bursa
26992 Incision, bone cortex, pelvis and/or hip joint (eg, for osteomyelitis or bone abscess)
27000 Tenotomy, adductor of hip, percutaneous, (separate procedure)
27001 Tenotomy, adductor of hip, open
27003 Tenotomy, adductor, subcutaneous, open, with obturator neurectomy

27005 Tenotomy, hip flexor(s), open (separate procedure)
27006 Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)
27025 Fasciotomy, hip or thigh, any type
(For 27001, 27003, 27025, to report bilateral procedures, use modifier -50)
27027 Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/ or tensor fascia lata muscle), unilateral
(To report bilateral procedure, use modifier -50)
27030 Arthrotomy, hip, with drainage (eg, infection)
27033 Arthrotomy, hip, including exploration or removal of loose or foreign body
27035 Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral or obturator nerves
27036 Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)

EXCISION

27040 Biopsy, soft tissues of pelvis and hip area; superficial
27041 deep subfascial or intramuscular
27043 Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater
27045 Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater
27047 Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm
27048 Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm
27049 Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm
27050 Arthrotomy, with biopsy; sacroiliac joint
27052 hip joint
27054 Arthrotomy with synovectomy, hip joint
27057 Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/ or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral
(To report bilateral procedure, use modifier -50)
27059 Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater
27060 Excision; ischial bursa
27062 trochanteric bursa or calcification
27065 Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; superficial, includes autograft, when performed
27066 deep (subfascial), includes autograft, when performed
27067 with autograft requiring separate incision
27070 Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial
27071 deep (subfascial or intramuscular)
27075 Radical resection of tumor or infection; wing of ilium, 1 pubic or ischial ramus or symphysis pubis
27076 ilium, including acetabulum, both pubic rami, or ischium and acetabulum

27077 innominate bone, total
27078 ischial tuberosity and greater trochanter of femur
27080 Coccygectomy, primary

INTRODUCTION OR REMOVAL

27086 Removal of foreign body, pelvis or hip; subcutaneous tissue
27087 deep (subfascial or intramuscular)
27090 Removal of hip prosthesis; (separate procedure)
27091 complicated, including total hip prosthesis, methylmethacrylate, with or without insertion of spacer
27093 Injection procedure for hip arthrography; without anesthesia
27095 with anesthesia
(For 27093, 27095 for radiological supervision and interpretation use 73525. Do not report 77002 in conjunction with 73525)
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)
(Code 27096 is a unilateral procedure. For bilateral procedure, use modifier 50)

REPAIR, REVISION, AND/OR RECONSTRUCTION

27097 Release or recession, hamstring, proximal
27098 Transfer, adductor to ischium
27100 Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft)
27105 Transfer paraspinal muscle to hip (includes fascial or tendon extension graft)
27110 Transfer iliopsoas; to greater trochanter of femur
27111 to femoral neck
27120 Acetabuloplasty; (eg, Whitman, Colonna Haygroves, or cup type)
27122 resection, femoral head (Girdlestone procedure)
27125 Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)
27130 Arthroplasty, acetabular and proximal femoral prosthetic replacement, (total hip arthroplasty), with or without autograft or allograft
27132 Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
27134 Revision of total hip arthroplasty; both components, with or without autograft or allograft
27137 acetabular component only, with or without autograft or allograft
27138 femoral component only, with or without allograft
27140 Osteotomy and transfer of greater trochanter of femur (separate procedure)
27146 Osteotomy, iliac, acetabular or innominate bone;
27147 with open reduction of hip
27151 with femoral osteotomy
27156 with femoral osteotomy and with open reduction of hip
27158 Osteotomy, pelvis, bilateral (eg, congenital malformation)

27161 Osteotomy, femoral neck (separate procedure)
27165 Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast
27170 Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)
27175 Treatment of slipped femoral epiphysis; by traction, without reduction
27176 by single or multiple pinning, in situ
27177 Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)
27178 closed manipulation with single or multiple pinning
27179 osteoplasty of femoral neck (Heyman type procedure)
27181 osteotomy and internal fixation
27185 Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur
27187 Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur

FRACTURE AND/OR DISLOCATION

27197 Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) or the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation
27198 with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)
27200 Closed treatment of coccygeal fracture
27202 Open treatment of coccygeal fracture
27215 Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, (eg, pelvic fracture(s) which do not disrupt the pelvic ring), with internal fixation
27216 Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)
27217 Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes pubic symphysis and/or ipsilateral superior/inferior rami)
27218 Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum)
(To report bilateral procedure, report 27215, 27216, 27217, 27218 with modifier -50)
27220 Closed treatment of acetabulum (hip socket) fracture(s); without manipulation
27222 with manipulation, with or without skeletal traction
27226 Open treatment of posterior or anterior acetabular wall fracture, with internal fixation
27227 Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation

27228 Open treatment of acetabular fracture(s) involving anterior and posterior (two) columns, includes T-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture; with internal fixation
27230 Closed treatment of femoral fracture, proximal end, neck; without manipulation
27232 with manipulation, with or without skeletal traction
27235 Percutaneous skeletal fixation of femoral fracture, proximal end, neck
27236 Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement
27238 Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; without manipulation
27240 with manipulation, with or without skin or skeletal traction
27244 Treatment of intertrochanteric, peritrochanteric or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage
27245 with intramedullary implant, with or without interlocking screws and/or cerclage
27246 Closed treatment of greater trochanteric fracture, without manipulation
27248 Open treatment of greater trochanteric fracture, includes internal fixation, when performed
27250 Closed treatment of hip dislocation, traumatic; without anesthesia
27252 requiring anesthesia
27253 Open treatment of hip dislocation, traumatic, without internal fixation
27254 Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation
27256 Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; without anesthesia, without manipulation
27257 with manipulation, requiring anesthesia
27258 Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc);
27259 with femoral shaft shortening
27265 Closed treatment of post hip arthroplasty dislocation; without anesthesia
27266 requiring regional or general anesthesia
27267 Closed treatment of femoral fracture, proximal end, head; without manipulation
27268 Closed treatment of femoral fracture, proximal end, head; with manipulation
27269 Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed

MANIPULATION

27275 Manipulation, hip joint, requiring general anesthesia

ARTHRODESIS

27279 Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device
27280 Arthrodesis, open, sacroiliac joint, (including obtaining bone graft), including instrumentation, when performed
(To report bilateral procedures, use modifier -50)

27282 Arthrodesis, symphysis pubis (including obtaining graft)
27284 Arthrodesis, hip joint (includes obtaining graft);
27286 with subtrochanteric osteotomy

AMPUTATION

27290 Interpelviabdominal amputation (hind quarter amputation)
27295 Disarticulation of hip

OTHER PROCEDURES

27299 Unlisted procedure, pelvis or hip joint

FEMUR (THIGH REGION) AND KNEE JOINT

Including tibial plateaus.

INCISION

27301 Incision and drainage of deep abscess, bursa, or hematoma, thigh or knee region
27303 Incision, deep with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess)
27305 Fasciotomy, iliotibial (tenotomy), open
27306 Tenotomy, percutaneous, adductor or hamstring, single tendon (separate procedure)
27307 multiple tendons
27310 Arthrotomy, knee, with exploration, drainage or removal of foreign body (eg, infection)

EXCISION

27323 Biopsy, soft tissue of thigh or knee area; superficial
27324 deep (subfascial or intramuscular)
27325 Neurectomy, hamstring muscle
27326 Neurectomy, popliteal (gastrocnemius)
27327 Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm
27328 Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm
27329 Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm (see 27364 for 5 cm or greater)
27330 Arthrotomy, knee; with synovial biopsy only
27331 including joint exploration, biopsy, or removal of loose or foreign bodies
27332 Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral
27333 medial AND lateral
27334 Arthrotomy, with synovectomy; knee, anterior OR posterior
27335 anterior AND posterior including popliteal area
27337 Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater
27339 Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater
27340 Excision, prepatellar bursa

27345 Excision of synovial cyst of popliteal space (eg, Baker's cyst)
27347 Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee
27350 Patellectomy or hemipatellectomy
27355 Excision or curettage of bone cyst or benign tumor of femur;
27356 with allograft
27357 with autograft (includes obtaining graft)
27358 with internal fixation
(List in addition to primary procedure)
(Use 27358 in conjunction with 27355, 27356, or 27357)
27360 Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)
27364 Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater (see 27329 for less than 5 cm)
27365 Radical resection of tumor, bone, femur or knee

INTRODUCTION OR REMOVAL

27369 Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography
(For radiological arthrography radiolological supervision and interpretation, use 73580)
27372 Removal foreign body, deep, thigh region or knee area

REPAIR, REVISION, AND/OR RECONSTRUCTION

27380 Suture of infrapatellar tendon; primary
27381 secondary reconstruction, including fascial or tendon graft
27385 Suture of quadriceps or hamstring muscle rupture; primary
27386 secondary reconstruction, including fascial or tendon graft
27390 Tenotomy, open, hamstring, knee to hip; single tendon
27391 multiple tendons, one leg
27392 multiple tendons, bilateral
27393 Lengthening of hamstring tendon; single tendon
27394 multiple tendons, one leg
27395 multiple tendons, bilateral
27396 Transplant or transfer (with muscle redirection or rerouting), thigh (eg, extensor to flexor); single tendon
27397 multiple tendons
27400 Transfer tendon or muscle, hamstrings to femur (eg, Eggers type procedure)
27403 Arthrotomy with open meniscus repair, knee
27405 Repair, primary, torn ligament and/or capsule, knee; collateral
27407 cruciate
27409 collateral and cruciate ligaments
27415 Osteochondral allograft, knee, open
27416 Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])

(Do not report 27416 in conjunction with 27415, 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)

27418 Anterior tibial tubercleplasty (eg, Maquet type procedure)
27420 Reconstruction of dislocating patella; (eg, Hauser type procedure)
27422 with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)
27424 with patellectomy
27425 Lateral retinacular release open
27427 Ligamentous reconstruction (augmentation), knee; extra-articular
27428 intra-articular (open)
27429 intra-articular (open) and extra-articular
27430 Quadricepsplasty (eg, Bennett or Thompson type)
27435 Capsulotomy, posterior release, knee
27437 Arthroplasty, patella; without prosthesis
27438 with prosthesis
27440 Arthroplasty, knee, tibial plateau;
27441 with debridement and partial synovectomy
27442 Arthroplasty, femoral condyles or tibial plateau(s), knee;
27443 with debridement and partial synovectomy
27445 Arthroplasty, knee, hinge prosthesis (eg, Walldius type)
27446 Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
27447 medial AND lateral compartments with or without patella resurfacing (total knee replacement)
27448 Osteotomy, femur, shaft or supracondylar; without fixation
27450 with fixation
27454 Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft, (eg, Sofield type procedure)
27455 Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)); before epiphyseal closure
27457 after epiphyseal closure
(To report 27448-27450, 27455-27457 as bilateral procedures, use modifier -50)
27465 Osteoplasty, femur; shortening (excluding 64876)
27466 lengthening
27468 combined, lengthening and shortening with femoral segment transfer
27470 Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)
27472 with iliac or other autogenous bone graft (includes obtaining graft)
27475 Arrest, epiphyseal, any method (eg, epiphysiodesis); distal femur
27477 tibia and fibula, proximal
27479 combined distal femur, proximal tibia and fibula
27485 Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, for genu varus or valgus)
27486 Revision of total knee arthroplasty, with or without allograft; one component
27487 femoral and entire tibial component

27488 Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee
27495 Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femur
27496 Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);
27497 with debridement of nonviable muscle and/or nerve
27498 Decompression fasciotomy, thigh and/or knee, multiple compartments;
27499 with debridement of nonviable muscle and/or nerve

FRACTURE AND/OR DISLOCATION

27500 Closed treatment of femoral shaft fracture, without manipulation
27501 Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation
27502 Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction
27503 Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension; with manipulation, with or without skin or skeletal traction
27506 Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws
27507 Open treatment of femoral shaft fracture with plate/screws, with or without cerclage
27508 Closed treatment of femoral fracture, distal end, medial or lateral condyle, without manipulation
27509 Percutaneous skeletal fixation of femoral fracture, distal end, medial or lateral condyle, or supracondylar or transcondylar, with or without intercondylar extension, or distal femoral epiphyseal separation
27510 Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation
27511 Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed
27513 Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed
27514 Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed
27516 Closed treatment of distal femoral epiphyseal separation; without manipulation
27517 with manipulation, with or without skin or skeletal traction
27519 Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed
27520 Closed treatment of patellar fracture, without manipulation
27524 Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair
27530 Closed treatment of tibial fracture, proximal (plateau); without manipulation
27532 with or without manipulation, with skeletal traction
27535 Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed

27536 bicondylar, with or without internal fixation
27538 Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation
27540 Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed
27550 Closed treatment of knee dislocation; without anesthesia
27552 requiring anesthesia
27556 Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction
27557 with primary ligamentous repair
27558 with primary ligamentous repair, with augmentation/reconstruction
27560 Closed treatment of patellar dislocation; without anesthesia
27562 requiring anesthesia
27566 Open treatment of patellar dislocation, with or without partial or total patellectomy

MANIPULATION

27570 Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)

ARTHRODESIS

27580 Arthrodesis, knee, any technique

AMPUTATION

27590 Amputation, thigh, through femur, any level;
27591 immediate fitting technique including first cast
27592 open, circular (guillotine)
27594 secondary closure or scar revision
27596 re-amputation
27598 Disarticulation at knee

OTHER PROCEDURES

27599 Unlisted procedure, femur or knee

LEG (TIBIA AND FIBULA) AND ANKLE JOINT

INCISION

27600 Decompression fasciotomy, leg; anterior and/or lateral compartments only
27601 posterior compartment(s) only
27602 anterior and/or lateral, and posterior compartment(s)
27603 Incision and drainage; deep abscess or hematoma

27604 infected bursa
27605 Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia
27606 general anesthesia
27607 Incision, (eg, osteomyelitis or bone abscess) leg or ankle
27610 Arthrotomy, ankle, including exploration, drainage or removal of foreign body
27612 Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening

EXCISION

27613 Biopsy, soft tissues; superficial
27614 deep (subfascial or intramuscular)
27615 Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm
27616 5 cm or greater
27618 Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm
27619 Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm
27620 Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body
27625 Arthrotomy, with synovectomy, ankle;
27626 including tenosynovectomy
27630 Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion), leg and/or ankle
27632 Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater
27634 Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater
27635 Excision or curettage of bone cyst or benign tumor, tibia or fibula;
27637 with autograft (includes obtaining graft)
27638 with allograft
27640 Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia
27641 fibula
27645 Radical resection of tumor; tibia
27646 fibula
27647 talus or calcaneus

INTRODUCTION OR REMOVAL

27648 Injection procedure for ankle arthrography
(For radiological supervision and interpretation, use 73615. Do not report 77002 in conjunction with 73615)

REPAIR, REVISION, AND/OR RECONSTRUCTION

27650 Repair, primary, open or percutaneous ruptured Achilles tendon;
27652 with graft (includes obtaining graft)
27654 Repair, secondary, ruptured Achilles tendon, with or without graft
27656 Repair, fascial defect of leg

27658 Repair or suture of flexor tendon, leg; primary, without graft, each tendon
27659 secondary with or without graft, each tendon
27664 Repair, extensor tendon, leg; primary, without graft, each tendon
27665 secondary with or without graft, each tendon
27675 Repair dislocating peroneal tendons; without fibular osteotomy
27676 with fibular osteotomy
27680 Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon
27681 multiple tendons (through same incision(s))
27685 Lengthening or shortening of tendon; leg or ankle; single tendon (separate procedure)
27686 multiple tendons (through same incision), each
27687 Gastrocnemius recession (eg, Strayer procedure)
27690 Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)
27691 deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)
27692 each additional tendon
(List separately in addition to primary procedure)
(Use 27692 in conjunction with 27690, 27691)
27695 Repair, primary, disrupted ligament, ankle; collateral
27696 both collateral ligaments
27698 Repair, secondary disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)
27700 Arthroplasty, ankle;
27702 with implant (total ankle)
27703 revision, total ankle
27704 Removal of ankle implant
27705 Osteotomy; tibia
27707 fibula
27709 tibia and fibula
27712 multiple, with realignment on intramedullary rod (eg, Sofield type procedure)
27715 Osteoplasty, tibia and fibula, lengthening or shortening
27720 Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)
27722 with sliding graft
27724 with iliac or other autograft (includes obtaining graft)
27725 by synostosis, with fibula, any method
27726 repair of fibula nonunion and/or malunion with internal fixation
(Do not report 27726 in conjunction with 27707)
27727 Repair of congenital pseudarthrosis, tibia
27730 Arrest, epiphyseal (epiphysiodesis), open; distal tibia
27732 distal fibula
27734 distal tibia and fibula
27740 Arrest epiphyseal, (epiphysiodesis), any method; combined, proximal and distal tibia and fibula;
27742 and distal femur
27745 Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia

FRACTURE AND/OR DISLOCATION

27750 Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation
27752 with manipulation, with or without skeletal traction
27756 Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture) (eg, pins or screws)
27758 Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with or without cerclage
27759 Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage
27760 Closed treatment of medial malleolus fracture; without manipulation
27762 with manipulation, with or without skin or skeletal traction
27766 Open treatment of medial malleolus fracture, includes internal fixation, when performed
27767 Closed treatment of posterior malleolus fracture; without manipulation
27768 with manipulation
27769 Open treatment of posterior malleolus fracture, includes internal fixation, when performed (Do not report 27767-27769 in conjunction with 27808-27823)
27780 Closed treatment of proximal fibula or shaft fracture; without manipulation
27781 with manipulation
27784 Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed
27786 Closed treatment of distal fibular fracture (lateral malleolus); without manipulation
27788 with manipulation
27792 Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed
27808 Closed treatment of bimalleolar ankle fracture, (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); without manipulation
27810 with manipulation
27814 Open treatment of bimalleolar ankle fracture, (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed
27816 Closed treatment of trimalleolar ankle fracture; without manipulation
27818 with manipulation
27822 Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip
27823 with fixation of posterior lip
27824 Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation
27825 with skeletal traction and/or requiring manipulation
27826 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation; when performed; of fibula only
27827 of tibia only
27828 of both tibia and fibula
27829 Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed

27830 Closed treatment of proximal tibiofibular joint dislocation; without anesthesia
27831 requiring anesthesia
27832 Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula
27840 Closed treatment of ankle dislocation; without anesthesia
27842 requiring anesthesia, with or without percutaneous skeletal fixation
27846 Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation
27848 with repair or internal or external fixation

MANIPULATION

27860 Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)

ARTHRODESIS

27870 Arthrodesis, ankle, open
27871 Arthrodesis, tibiofibular joint, proximal or distal

AMPUTATION

27880 Amputation leg, through tibia and fibula;
27881 with immediate fitting technique including application of first cast
27882 open, circular (guillotine)
27884 secondary closure or scar revision
27886 re-amputation
27888 Amputation, ankle, through malleoli of tibia and fibula (Syme, Pirogoff type procedures), with plastic closure and resection of nerves
27889 Ankle disarticulation

OTHER PROCEDURES

27892 Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve
27893 posterior compartment(s) only, with debridement of nonviable muscle and/or nerve
27894 anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve
27899 Unlisted procedure, leg or ankle

FOOT AND TOES

INCISION

28001 Incision and drainage bursa, foot
28002 Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space

28003 multiple areas
28005 Incision, bone cortex (eg, for osteomyelitis or bone abscess), foot
28008 Fasciotomy, foot and/or toe
(See also 28060, 28062, 28250)
28010 Tenotomy, percutaneous, toe; single tendon
28011 multiple tendons
28020 Arthrotomy, with exploration, drainage or removal of loose or foreign body; intertarsal or tarsometatarsal joint
28022 metatarsophalangeal joint
28024 interphalangeal joint
28035 Release, tarsal tunnel (posterior tibial nerve decompression)

EXCISION

28039 Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater
28041 Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater
28043 Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm
28045 Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm
28046 Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm
28047 3 cm or greater
28050 Arthrotomy with biopsy; intertarsal or tarsometatarsal joint
28052 metatarsophalangeal joint
28054 interphalangeal joint
28055 Neurectomy, intrinsic musculature of foot
28060 Fasciectomy, plantar fascia; partial (separate procedure)
28062 radical (separate procedure)
28070 Synovectomy; intertarsal or tarsometatarsal joint, each
28072 metatarsophalangeal joint, each
28080 Excision of interdigital (Morton) neuroma, single, each
28086 Synovectomy, tendon sheath, foot; flexor
28088 extensor
28090 Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (cyst or ganglion); foot
28092 toe(s), each
28100 Excision or curettage of bone cyst or benign tumor, talus or calcaneus;
28102 with iliac or other autograft (includes obtaining graft)
28103 with allograft
28104 Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus;
28106 with iliac or other autograft (includes obtaining graft)
28107 with allograft
28108 Excision or curettage of bone cyst or benign tumor, phalanges of foot
28110 Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
28111 Ostectomy, complete excision; first metatarsal head
28112 other metatarsal head (second, third or fourth)

28113 fifth metatarsal head
28114 all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (Clayton type procedure)
28116 Ostectomy, excision of tarsal coalition
28118 Ostectomy, calcaneus;
28119 for spur, with or without plantar fascial release
28120 Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus
28122 tarsal or metatarsal bone except talus or calcaneus
28124 phalanx of toe
28126 Resection, partial or complete, phalangeal base, each toe
28130 Talectomy (astragalectomy)
28140 Metatarsectomy
28150 Phalangectomy, toe, each toe
28153 Resection, condyle(s), distal end of phalanx, each toe
28160 Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each
28171 Radical resection of tumor; tarsal (except talus or calcaneus)
28173 metatarsal
28175 phalanx of toe

INTRODUCTION OR REMOVAL

28190 Remove foreign body, foot; subcutaneous
28192 deep
28193 complicated

REPAIR, REVISION, AND/OR RECONSTRUCTION

28200 Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon
28202 secondary with free graft, each tendon (includes obtaining graft)
28208 Repair, tendon, extensor, foot; primary or secondary, each tendon
28210 secondary with free graft, each tendon (includes obtaining graft)
28220 Tenolysis, flexor, foot; single tendon
28222 multiple tendons
28225 Tenolysis, extensor, foot; single tendon
28226 multiple tendons
28230 Tenotomy, open, tendon flexor; foot, single or multiple tendon(s) (separate procedure)
28232 toe, single tendon (separate procedure)
28234 Tenotomy, open, extensor, foot or toe, each tendon
28238 Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)
28240 Tenotomy lengthening, or release, abductor hallucis muscle
28250 Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure)
28260 Capsulotomy, midfoot; medial release only (separate procedure)
28261 with tendon lengthening

28262 extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)
28264 Capsulotomy, midtarsal (eg, Heyman type procedure)
28270 Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)
28272 interphalangeal joint, each joint (separate procedure)
28280 Syndactylization, toes (eg, webbing or Kelikian type procedure)
28285 Correction, hammertoe; (eg, interphalangeal fusion, partial or total phalangectomy)
28286 Correction, cock-up fifth toe, with plastic skin closure (Ruiz-Mora type procedure)
28288 Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head
28289 Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant
28291 with implant
28292 Correction, hallux valgus (bunionectomy), with sesamoidectomy when performed;with resection of proximal phalanx base, when performed, any method
28296 with distal metatarsal osteotomy, any method
28295 with proximal metatarsal osteotomy, any method
28297 with first metatarsal and medical cuneiform joint arthrodesis, any method
28298 with proximal phalanx osteotomy, any method
28299 with double osteotomy, any method
28300 Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation
28302 talus
28304 Osteotomy, tarsal bones, other than calcaneus or talus;
28305 with autograft (includes obtaining graft) (eg, Fowler type)
28306 Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal
28307 first metatarsal with autograft (other than first toe)
28308 other than first metatarsal, each
28309 multiple, (eg, Swanson type cavus foot procedure)
28310 Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
28312 other phalanges, any toe
28313 Reconstruction, angular deformity of toe, soft tissue procedures only (overlapping second toe, fifth toe, curly toes)
28315 Sesamoidectomy, first toe (separate procedure)
28320 Repair of nonunion or malunion; tarsal bones
28322 metatarsal, with or without bone graft (includes obtaining graft)
28340 Reconstruction, toe, macrodactyly; soft tissue resection
28341 requiring bone resection
28344 Reconstruction, toe(s); polydactyly
28345 syndactyly, with or without skin graft(s), each web
28360 Reconstruction, cleft foot

FRACTURE AND/OR DISLOCATION

28400 Closed treatment of calcaneal fracture; without manipulation
28405 with manipulation
28406 Percutaneous skeletal fixation of calcaneal fracture, with manipulation
28415 Open treatment of calcaneal fracture, includes internal fixation, when performed;
28420 with primary iliac or other autogenous bone graft (includes obtaining graft)
28430 Closed treatment of talus fracture; without manipulation
28435 with manipulation
28436 Percutaneous skeletal fixation of talus fracture, with manipulation
28445 Open treatment of talus fracture, includes internal fixation, when performed
28446 Open osteochondral autograft, talus (includes obtaining graft[s])
(Do not report 28446 in conjunction with 27705, 27707)
28450 Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each
28455 with manipulation, each
28456 Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each
28465 Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each
28470 Closed treatment of metatarsal fracture; without manipulation, each
28475 with manipulation, each
28476 Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each
28485 Open treatment of metatarsal fracture, includes internal fixation, when performed, each
28490 Closed treatment of fracture great toe, phalanx or phalanges; without manipulation
28495 with manipulation
28496 Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges, with manipulation
28505 Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed
28510 Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each
28515 with manipulation, each
28525 Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each
28530 Closed treatment of sesamoid fracture
28531 Open treatment of sesamoid fracture, with or without internal fixation
28540 Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia
28545 requiring anesthesia
28546 Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation
28555 Open treatment of tarsal bone dislocation, includes internal fixation, when performed
28570 Closed treatment of talotarsal joint dislocation; without anesthesia
28575 requiring anesthesia
28576 Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation
28585 Open treatment of talotarsal joint dislocation, includes internal fixation, when performed
28600 Closed treatment of tarsometatarsal joint dislocation; without anesthesia
28605 requiring anesthesia
28606 Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation

28615 Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed
28630 Closed treatment of metatarsophalangeal joint dislocation; without anesthesia
28635 requiring anesthesia
28636 Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation
28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed
28660 Closed treatment of interphalangeal joint dislocation; without anesthesia
28665 requiring anesthesia
28666 Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation
28675 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed

ARTHRODESIS

28705 Arthrodesis, pantalar
28715 triple
28725 subtalar
28730 Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;
28735 with osteotomy (eg, flatfoot correction)
28737 Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal, navicular-cuneiform (eg, Miller type procedure)
28740 Arthrodesis, midtarsal or tarsometatarsal, single joint
28750 Arthrodesis, great toe; metatarsophalangeal joint
28755 interphalangeal joint
28760 Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint, (eg, Jones type procedure)

AMPUTATION

28800 Amputation, foot; midtarsal (eg, Chopart type procedure)
28805 transmetatarsal
28810 Amputation, metatarsal, with toe, single
28820 Amputation, toe; metatarsophalangeal joint
28825 interphalangeal joint

OTHER PROCEDURES

28899 Unlisted procedure, foot or toes

APPLICATION OF CASTS AND STRAPPING

(Separate Procedure Only)

The listed procedures apply to the application of a cast or strapping. Listed procedures include removal of cast or strapping. Use code 99070 for cost of materials.

BODY AND UPPER EXTREMITY

CASTS

29000 Application of halo type body cast
29010 Application of Risser jacket, localizer, body; only
29015 including head
29035 Application of body cast, shoulder to hips;
29040 including head, Minerva type
29044 including one thigh
29046 including both thighs
29049 Application, cast; figure-of-eight
29055 shoulder spica
29058 plaster Velpeau
29065 shoulder to hand (long arm)
29075 elbow to finger (short arm)
29085 hand and lower forearm (gauntlet)
29086 finger (eg, contracture)

SPLINTS

29105 Application of long arm splint (shoulder to hand)
29125 Application of short arm splint (forearm to hand); static
29126 dynamic

LOWER EXTREMITY

CASTS

29305 Application of hip spica cast; one leg
29325 one and one-half spica or both legs
29345 Application of long leg cast (thigh to toes);
29355 walker or ambulatory type
29358 Application of long leg cast brace
29365 Application of cylinder cast (thigh to ankle)
29405 Application of short leg cast (below knee to toes);
29425 walking or ambulatory type
29435 Application of patellar tendon bearing (PTB) cast
29440 Adding walker to previously applied cast
29445 Application of rigid total contact leg cast
29450 Application of clubfoot cast with molding or manipulation, long or short leg

SPLINTS

29505 Application of long leg splint (thigh to ankle or toes)
29515 Application of short leg splint (calf to foot)

STRAPPING-ANY AGE

29580 Strapping; Unna boot
29581 Application of multi-layer compression system; leg (below knee), including ankle and foot
29584 upper arm, forearm, hand, and fingers

REMOVAL OR REPAIR

Codes for cast removals should be employed only for casts applied by another physician.

29700 Removal of bivalving; gauntlet, boot or body cast
29705 full arm or full leg cast
29710 shoulder or hip spica, Minerva, or Risser jacket, etc
29720 Repair of spica, body cast or jacket
29730 Windowing of cast
29740 Wedging of cast (except clubfoot casts)
29750 Wedging of clubfoot cast
(To report bilateral procedure, use modifier -50)

OTHER PROCEDURES

29799 Unlisted procedure, casting or strapping

ENDOSCOPY/ARTHROSCOPY

Surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthroscopy.

29800 Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)
29804 Arthroscopy, temporomandibular joint, surgical
29805 Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
29806 Arthroscopy, shoulder, surgical; capsulorrhaphy
29807 repair of slap lesion
29819 Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
29820 synovectomy, partial
29821 synovectomy, complete
29822 debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
29823 debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
29824 distal claviculectomy including distal articular surface (Mumford procedure)
29825 with lysis and resection of adhesions with or without manipulation

29826 decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed
(List separately in addition to primary procedure)
Use 29826 in conjunction with 29806-29825, 29827, 29828)
29827 with rotator cuff
29828 Arthroscopy, shoulder, surgical; biceps tenodesis
(Do not report 29828 in conjunction with 29805, 29820, 29822)
29830 Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
29834 Arthroscopy, elbow, surgical; with removal of loose body or foreign body
29835 synovectomy, partial
29836 synovectomy, complete
29837 debridement, limited
29838 debridement, extensive
29840 Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)
29843 Arthroscopy, wrist, surgical; for infection, lavage and drainage
29844 synovectomy, partial
29845 synovectomy, complete
29846 excision and/or repair of triangular fibrocartilage and/or joint debridement
29847 internal fixation for fracture or instability
29848 Endoscopy, wrist, surgical, with release of transverse carpal ligament
29850 Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)
29851 with internal or external fixation (includes arthroscopy)
29855 Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed (includes arthroscopy)
29856 bicondylar, includes internal fixation, when performed (includes arthroscopy)
29860 Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)
29861 Arthroscopy, hip, surgical; with removal of loose body or foreign body
29862 with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
29863 with synovectomy
29866 Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])
(Do not report 29866 in conjunction with 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)
29867 osteochondral allograft (eg, mosaicplasty)
(Do not report 29867 in conjunction with 27570, 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)
(Do not report 29867 in conjunction with 27415)
29868 meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
(Do not report 29868 in conjunction with 29870, 29871, 29875, 29880, 29883, 29884 when performed at the same session or 29874, 29877, 29881, 29882 when performed in the same compartment)

29870 Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29871 Arthroscopy, knee, surgical; for infection, lavage and drainage
29873 with lateral release
29874 for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)
29875 synovectomy, limited (eg, plica or shelf resection) (separate procedure)
29876 synovectomy, major, two or more compartments (eg, medial or lateral)
29877 debridement/shaving of articular cartilage (chondroplasty)
29879 abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
29880 with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29881 with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29882 with meniscus repair (medial or lateral)
29883 with meniscus repair (medial and lateral)
29884 with lysis of adhesions with or without manipulation (separate procedure)
29885 drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)
29886 drilling for intact osteochondritis dissecans lesion
29887 drilling for intact osteochondritis dissecans lesion with internal fixation
29888 Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29889 Arthroscopically aided posterior cruciate ligament repair/ augmentation or reconstruction (Procedures 29888 and 29889 should not be used with reconstruction procedures 27427-27429)
29891 Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and/or tibia, including drilling of the defect
29892 Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)
29893 Endoscopic plantar fasciotomy
29894 Arthroscopy ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body
29895 synovectomy, partial
29897 debridement, limited
29898 debridement, extensive
29899 with ankle arthrodesis
29900 Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy (Do not report 29900 with 29901, 29902)
29901 Arthroscopy, metacarpophalangeal joint, surgical; with debridement
29902 with reduction of displaced ulnar collateral ligament (eg, Stenar Lesion)
29904 Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body
29905 Arthroscopy, subtalar joint, surgical; with synovectomy
29906 Arthroscopy, subtalar joint, surgical; with debridement

29907 Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis
29914 Arthroscopy, hip, surgical; with removal of loose body or foreign body with femoroplasty (ie., treatment of cam lesion)
29915 with acetabuloplasty (ie, treatment of pincer lesion)
(Do not report 29914, 29915 in conjunction with 29862, 29863)
29916 with labral repair
(Do not report 29916 for labral repair secondary to acetabuloplasty or in conjunction with 29862, 29863)
29999 Unlisted procedure, arthroscopy

RESPIRATORY SYSTEM

NOSE

INCISION

30000 Drainage abscess or hematoma, nasal, internal approach
30020 Drainage abscess or hematoma, nasal septum

EXCISION

30100 Biopsy, intranasal
30110 Excision, nasal polyp(s), simple
(30110 would normally be completed in an office setting)
(To report bilateral procedure, use modifier -50)
30115 Excision, nasal polyp(s), extensive
(30115 would normally require the facilities available in a hospital setting)
(To report bilateral procedure, use modifier -50)
30117 Excision or destruction, (eg, laser), intranasal lesion; internal approach
30118 external approach (lateral rhinotomy)
30120 Excision or surgical planing of skin of nose for rhinophyma
30124 Excision dermoid cyst, nose; simple, skin, subcutaneous
30125 complex, under bone or cartilage
30130 Excision inferior turbinate, partial or complete, any method
30140 Submucous resection inferior turbinate, partial or complete, any method
(Do not report 30130 or 30140 in conjunction with 30801, 30802, 30930)
30150 Rhinectomy; partial
30160 total

INTRODUCTION

30200 Injection into turbinate(s), therapeutic
30210 Displacement therapy (Proetz type)
30220 Insertion, nasal septal prosthesis (button)

REMOVAL OF FOREIGN BODY

30300 Removal foreign body, intranasal; office type procedure
30310 requiring general anesthesia
30320 by lateral rhinotomy

REPAIR

30400 Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410 complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420 including major septal repair
30430 Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435 intermediate revision (bony work with osteotomies)
30450 major revision (nasal tip work and osteotomies)
30460 Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462 tip, septum, osteotomies
30465 Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
(30465 excludes obtaining graft. For graft procedure, see 20900-20926, 21210)
(30465 is used to report a bilateral procedure)
30468 Repair of nasal valve collapse with subcutaneous/ submucosal lateral wall implant(s)
30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30540 Repair choanal atresia; intranasal
30545 transpalatine
(Do not report modifier –63 in conjunction with 30540, 30545)
30560 Lysis intranasal synechia
30580 Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)
30600 oronasal
30620 Septal or other intranasal dermatoplasty (does not include obtaining graft)
30630 Repair nasal septal perforations

DESTRUCTION

30801 Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method, (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial
(Do not report 30801in conjunction with 30802)
30802 intramural; (ie, submucosal)
(Do not report 30801, 30802, 30930 in conjunction with 30130 or 30140)

OTHER PROCEDURES

30901 Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
(To report bilateral procedure, use modifier -50)
30903 Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method

(To report bilateral procedure, use modifier -50)
30905 Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial
30906 subsequent
30915 Ligation arteries; ethmoidal
30920 internal maxillary artery, transantral
30930 Fracture nasal inferior turbinate(s), therapeutic
(Do not report 30801, 30802, 30930 in conjunction with 30130 or 30140)
30999 Unlisted procedure, nose

ACCESSORY SINUSES

INCISION

31000 Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)
31002 sphenoid sinus
31020 Sinusotomy, maxillary (antrotomy); intranasal
31030 radical (Caldwell-Luc) without removal of antrochoanal polyps
31032 radical (Caldwell-Luc) with removal antrochoanal polyps
31040 Pterygomaxillary fossa surgery, any approach
31050 Sinusotomy, sphenoid, with or without biopsy;
31051 with mucosal stripping or removal of polyp(s)
31070 Sinusotomy frontal; external, simple (trephine operation)
31075 transorbital, unilateral (for mucocele or osteoma, Lynch type)
31080 obliterative without osteoplastic flap, brow incision (includes ablation)
31081 obliterative, without osteoplastic flap, coronal incision (includes ablation)
31084 obliterative, with osteoplastic flap, brow incision
31085 obliterative, with osteoplastic flap, coronal incision
31086 nonobliterative, with osteoplastic flap, brow incision
31087 nonobliterative, with osteoplastic flap, coronal incision
31090 Sinusotomy, unilateral, three or more paranasal sinuses, (frontal, maxillary, ethmoid, sphenoid)

EXCISION

31200 Ethmoidectomy; intranasal, anterior
31201 intranasal, total
31205 extranasal, total
31225 Maxillectomy; without orbital exenteration
31230 with orbital exenteration (en bloc)

ENDOSCOPY

A surgical sinus endoscopy includes a sinusotomy (when appropriate) and diagnostic endoscopy. Codes 31233-31297 are used to report unilateral procedures unless otherwise specified. The codes 31231-31235 for diagnostic evaluation refer to employing a nasal/sinus endoscope to inspect the interior of the nasal cavity and the middle and superior meatus, the turbinates, and the spheno-

ethmoid recess. Any time a diagnostic evaluation is performed all these areas would be inspected and a separate code is not reported for each area.

31231 Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
31233 Nasal/sinus endoscopy, diagnostic; with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)
31235 with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)
31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)
31238 with control of nasal hemorrhage
31239 with dacryocystorhinostomy
31240 with concha bullosa resection
31241 with ligation of sphenopalatine artery
31254 Nasal/sinus endoscopy, surgical; with ethmoidectomy; partial (anterior)
31255 total (anterior and posterior)
31253 total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed
31257 total (anterior and posterior), including sphenoidotomy
31259 total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus
31256 Nasal/sinus endoscopy, surgical, with maxillary antrostomy;
31267 with removal of tissue from maxillary sinus
31276 Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed
31287 Nasal/sinus endoscopy, surgical, with sphenoidotomy;
31288 with removal of tissue from sphenoid sinus
31290 Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region
31291 sphenoid region
31292 Nasal/sinus endoscopy, surgical, with orbital decompression; medial or inferior wall
31293 medial and inferior wall
31294 Nasal/sinus endoscopy, surgical, with optic nerve decompression
31295 Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa
31296 frontal sinus ostium
31297 sphenoid sinus ostium
31298 frontal and sphenoid sinus ostia

OTHER PROCEDURES

31299 Unlisted procedure, accessory sinuses

LARYNX

EXCISION

31300 Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectomy
31360 Laryngectomy; total, without radical neck dissection
31365 total, with radical neck dissection
31367 subtotal supraglottic, without radical neck dissection
31368 subtotal supraglottic, with radical neck dissection
31370 Partial laryngectomy (hemilaryngectomy); horizontal
31375 laterovertical
31380 anterovertical
31382 antero-latero-vertical
31390 Pharyngolaryngectomy, with radical neck dissection; without reconstruction
31395 with reconstruction
31400 Arytenoidectomy or arytenoidopexy, external approach
31420 Epiglottidectomy

INTRODUCTION

31500 Intubation, endotracheal, emergency procedure

ENDOSCOPY

For endoscopic procedures, code appropriate endoscopy of each anatomic site examined. If using operating microscope, telescope, or both, use the applicable code only once per operative session.

31505 Laryngoscopy, indirect; diagnostic (separate procedure)
31510 with biopsy
31511 with removal of foreign body
31512 with removal of lesion
31513 with vocal cord injection
31515 Laryngoscopy, direct, with or without tracheoscopy; for aspiration
31520 diagnostic, newborn
(Do not report 31520 with modifier –63)
31525 diagnostic, except newborn
31526 diagnostic, with operating microscope or telescope
31527 with insertion of obturator
31528 with dilation, initial
31529 with dilation, subsequent
31530 Laryngoscopy, direct, operative, with foreign body removal;
31531 with operating microscope or telescope
31535 Laryngoscopy, direct, operative, with biopsy;
31536 with operating microscope or telescope
31540 Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis;
31541 with operating microscope or telescope
31545 Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)
31546 reconstruction with graft(s) (includes obtaining autograft)

(Do not report 31546 in addition to 20926 for graft harvest)
(Do not report 31545 or 31546 in conjunction with 31540, 31541)
31560 Laryngoscopy, direct, operative, with arytenoidectomy;
31561 with operating microscope or telescope
31570 Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;
31571 with operating microscope or telescope
31575 Laryngoscopy, flexible; diagnostic
31576 with biopsy(ies)
31577 with removal of foreign body(s)
31578 with removal of lesion(s), non-laser
31572 with ablation or destruction of lesion(s) with laser, unilateral
31573 with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral
31574 with injection(s) for augmentation (eg, percutaneous, transoral), unilateral
31579 Laryngoscopy, flexible or rigid telescopic, with stroboscopy

REPAIR

31580 Laryngoplasty; for laryngeal web, two stage, with indwelling keel insertion
31551 for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age
31552 for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older
31553 for laryngeal stenosis, with graft, with indwelling stent placement, younger than 12 years of age
31554 for laryngeal stenosis, with graft, with indwelling stent placement, age 12 years or older
31584 with open reduction and fixation of (eg, plating) of fracture, includes tracheostomy if performed
31587 Laryngoplasty, cricoid split, without graft placement
31590 Laryngeal reinnervation by neuromuscular pedicle
31591 Laryngoplasty, medialization, unilateral
31592 Cricotracheal resection

DESTRUCTION

OTHER PROCEDURES

31599 Unlisted procedure, larynx

TRACHEA AND BRONCHI

INCISION

31600 Tracheostomy, planned (separate procedure);
31601 under two years
31603 Tracheostomy, emergency procedure; transtracheal

31605 cricothyroid membrane
31610 Tracheostomy, fenestration procedure with skin flaps
31611 Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)
31612 Tracheal puncture, percutaneous with transtracheal aspiration and/or injection
31613 Tracheostoma revision; simple, without flap rotation
31614 complex, with flap rotation

ENDOSCOPY

For endoscopy procedures, code appropriate endoscopy of each anatomic site examined. Surgical bronchoscopy always includes diagnostic bronchoscopy when performed by the same physician. Codes 31622-31646 include fluoroscopic guidance, when performed.

31615 Tracheobronchoscopy through established tracheostomy incision
31622 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)
31623 with brushing or protected brushings
31624 with bronchial alveolar lavage
31625 with bronchial or endobronchial biopsy(s), single or multiple sites
31626 with placement of fiducial markers, single or multiple
(Report supply of device separately)
31628 with transbronchial lung biopsy(s), single lobe
(31628 should be reported only once regardless of how many transbronchial lung biopsies are performed in a lobe)
31629 with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)
(31629 should be reported only once for upper airway biopsies regardless of how many transbronchial needle aspiration biopsies are performed in the upper airway or in a lobe)
31630 with tracheal/bronchial dilation or closed reduction of fracture
31631 with placement of tracheal stent(s) (includes tracheal/ bronchial dilation as required)
31632 with transbronchial lung biopsy(s), each additional lobe
(List separately in addition to primary procedure)
(Use 31632 in conjunction with 31628)
(31632 should be reported only once regardless of how many transbronchial lung biopsies are performed in a lobe)
31633 with transbronchial needle aspiration biopsy(s), each additional lobe
(List separately in addition to primary procedure)
(Use 31633 in conjunction with 31629)
(31633 should be reported only once regardless of how many transbronchial needle aspiration biopsies are performed in the trachea or the additional lobe)
31634 with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed
31635 with removal of foreign body
31636 with placement of bronchial stent(s) (includes tracheal/ bronchial dilation as required), initial bronchus

31637 each additional major bronchus stented
(List separately in addition to primary procedure)
(Use 31637 in conjunction with 31636)
31638 with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)
31640 with excision of tumor
31641 with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)
31643 with placement of catheter(s) for intracavitary radioelement application
31645 with therapeutic aspiration of tracheobronchial tree, initial
31646 with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay
31647 with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe
31651 with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe
(List separately in addition to primary procedure[s])
31648 with removal of bronchial valve(s), initial lobe
31649 with removal of bronchial valve(s), each additional lobe
(List separately in addition to primary procedure)
31652 with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures
31653 with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures
31654 with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s)
(List separately in addition to code for primary procedure[s])
(Use 31654 in conjunction with 31622, 31623, 31624, 31625, 31626, 31628,31629, 31640, 31643, 31645, 31646)
(For EBUS to access mediastinal or hilar lymph node station(s) of adjacent structure(s), see 31652, 31653)
(Report 31652, 31653, 31654 only once per session)

INTRODUCTION

31717 Catheterization with bronchial brush biopsy
31720 Catheter aspiration (separate procedure); nasotreacheal
31725 tracheobronchial with fiberscope, bedside
31730 Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen therapy

EXCISION, REPAIR

31750 Tracheoplasty; cervical

31755 tracheopharyngeal fistulization, each stage
31760 intrathoracic
31766 Carinal reconstruction
31770 Bronchoplasty; graft repair
31775 excision stenosis and anastomosis
31780 Excision tracheal stenosis and anastomosis; cervical
31781 cervicothoracic
31785 Excision of tracheal tumor or carcinoma; cervical
31786 thoracic
31800 Suture of tracheal wound or injury; cervical
31805 intrathoracic
31820 Surgical closure tracheostomy or fistula; without plastic repair
31825 with plastic repair
31830 Revision of tracheostomy scar

OTHER PROCEDURES

31899 Unlisted procedure, trachea, bronchi

LUNGS AND PLEURA

INCISION

32035 Thoracostomy; with rib resection for empyema
32036 with open flap drainage for empyema
32096 Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
32097 Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
(Do not report 32096 or 32097 in conjunction with 32440, 32442, 32445, 32488)
32098 Thoracotomy, with biopsy(ies) of pleura
32100 Thoracotomy; with exploration
(Do not report 32100 in conjunction with 19260, 19271, 19272, 32503, 32504)
32110 with control of traumatic hemorrhage and/or repair of lung tear
32120 for postoperative complications
32124 with open intrapleural pneumonolysis
32140 with cyst(s) removal, includes pleural procedure when performed
32141 with resection-plication of bullae, includes any pleural procedure when performed
32150 with removal of intrapleural foreign body or fibrin deposit
32151 with removal of intrapulmonary foreign body
32160 with cardiac massage
32200 Pneumonostomy; with open drainage of abscess or cyst
32215 Pleural scarification for repeat pneumothorax
32220 Decortication, pulmonary (separate procedure); total
32225 partial

EXCISION

32310 Pleurectomy; parietal (separate procedure)
32320 Decortication and parietal pleurectomy
32400 Biopsy, pleura; percutaneous needle
32408 Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when preformed

REMOVAL

32440 Removal of lung, pneumonectomy;
32442 with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)
32445 extrapleural
32480 Removal of lung, other than pneumonectomy; single lobe (lobectomy)
32482 2 lobes (bilobectomy)
32484 single segment (segmentectomy)
32486 with circumferential resection of segment of bronchus followed by broncho bronchial-anastomosis (sleeve lobectomy)
32488 with all remaining lung following previous removal of a portion of lung (completion pneumonectomy)
32491 with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed
32501 Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy
(List separately in addition to primary procedure)
(Use 32501 in conjunction with codes 32480, 32482, 32484)
(32501 is to be used when a portion of the bronchus to preserved lung is removed and requires plastic closure to preserve function of that preserved lung. It is not to be used for closure for the proximal end of a resected bronchus)
32503 Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction(s)
32504 with chest wall reconstruction
(Do not report 32503, 32504 in conjunction with 19260, 19271, 19272, 32100, 32551)
32505 Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial
(Do not report 32505 in conjunction with 32440, 32442, 32445, 32488)
32506 with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral
(List separately in addition to primary procedure)
(Report 32506 only in conjunction with 32505)
32507 with diagnostic wedge resection followed by anatomic lung resection
(List separately in addition to primary procedure)
(Report 32507 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504)
32540 Extrapleural enucleation of empyema (empyemectomy);

INTRODUCTION AND REMOVAL

32550 Insertion of indwelling tunneled pleural catheter with cuff
(Do not report 32550 in conjunction with 32554, 32555)
32551 Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)
(Do not report 32551 in conjunction with 19260, 19271, 19272, 32503, 32504)
32552 Removal of indwelling tunneled pleural catheter with cuff
32553 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple
(Report supply of device separately)
32554 Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance
32555 with imaging guidance
32556 Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance
32557 with imaging guidance

DESTRUCTION

32560 Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)
32561 Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day
32562 subsequent day

ENDOSCOPY

Surgical thoracoscopy always includes diagnostic thoracoscopy.

For endoscopic procedures, code appropriate endoscopy of each anatomic site examined.

32601 Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without biopsy
32604 pericardial sac, with biopsy
32606 mediastinal space, with biopsy
32607 Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
(Do not report 32607 in conjunction with 32440, 32442, 32445, 32488, 32671)
32608 with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
(Do not report 32608 in conjunction with 32440, 32442, 32445, 32488, 32671)
32609 with biopsy(ies) of pleura
32650 Thoracoscopy, surgical; with pleurodesis, (eg, mechanical or chemical)
32651 with partial pulmonary decortication
32652 with total pulmonary decortication, including intrapleural pneumonolysis
32653 with removal of intrapleural foreign body or fibrin deposit
32654 with control of traumatic hemorrhage
32655 with resection-plication of bullae, includes any pleural procedure when performed
32656 with parietal pleurectomy

32658 with removal of clot or foreign body from pericardial sac
32659 with creation of pericardial window or partial resection of pericardial sac for drainage
32661 with excision of pericardial cyst, tumor, or mass
32662 with excision of mediastinal cyst, tumor, or mass
32663 with lobectomy (single lobe)
32664 with thoracic sympathectomy
32665 with esophagomyotomy (Heller type)
32666 with therapeutic wedge resection (eg, mass, nodule), initial unilateral
32667 with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral
(List separately in addition to primary code)
(Report 32667 only in conjunction with 32666)
32668 with diagnostic wedge resection followed by anatomic lung resection
(List separately in addition to primary code)
(Report 32668 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32663, 32669, 32670, 32671)
32669 with removal of a single lung segment (segmentectomy)
32670 with removal of two lobes (bilobectomy)
32671 with removal of lung (pneumonectomy)
32672 with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed
32673 with resection of thymus, unilateral or bilateral
32674 with mediastinal and regional lymphadenectomy
(List separately in addition to primary procedure)
(Report 32674 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32505, 32663, 32666, 32667, 32669, 32670, 32671)

STEREOTACTIC RADIATION THERAPY

32701 Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment

REPAIR

32800 Repair lung hernia through chest wall
32810 Closure of chest wall following open flap drainage for empyema (Clagett type procedure)
32815 Open closure of major bronchial fistula
32820 Major reconstruction, chest wall (post-traumatic)

LUNG TRANSPLANTATION

32851 Lung transplant, single; without cardiopulmonary bypass
32852 with cardiopulmonary bypass
32853 Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass
32854 with cardiopulmonary bypass

SURGICAL COLLAPSE THERAPY; THORACOPLASTY

32900 Resection of ribs, extrapleural, all stages
32905 Thoracoplasty, Schede type or extrapleural (all stages);
32906 with closure of bronchopleural fistula
32940 Pneumonolysis, extraperiosteal, including filling or packing procedures
32960 Pneumothorax, therapeutic, intrapleural injection of air

OTHER PROCEDURES

32997 Total lung lavage (unilateral)
32998 Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency
32999 Unlisted procedure, lungs and pleura

CARDIOVASCULAR SYSTEM

Selective vascular catheterizations should be coded to include introduction and all lesser order selective catheterizations used in the approach (eg, the description for a selective right middle cerebral artery catheterization includes the introduction and placement catheterization of the right common and internal carotid arteries).

Additional second and/or third order arterial catheterizations within the same family of arteries supplied by a single first order artery should be expressed by 36218 or 36248. Additional first order or higher catheterizations in vascular families supplied by a first order vessel different from a previously selected and coded family should be separately coded using the conventions described above.

HEART AND PERICARDIUM

PERICARDIUM

33016 Pericardiocentesis, including imaging guidance, when performed
33017 Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly
33018 birth through 5 years of age or any age with congenital cardiac anomaly
33019 Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT guidance
33020 Pericardiotomy for removal of clot or foreign body (primary procedure)
33025 Creation of pericardial window or partial resection for drainage
33030 Pericardiectomy, subtotal or complete; without cardiopulmonary bypass
33031 with cardiopulmonary bypass
33050 Resection of pericardial cyst or tumor

CARDIAC TUMOR

33120 Excision of intracardiac tumor, resection with cardiopulmonary bypass
33130 Resection of external cardiac tumor

TRANSMYOCARDIAL REVASCULARIZATION

33140 Transmyocardial laser revascularization, by thoracotomy (separate procedure)
33141 performed at the time of other open cardiac procedure(s)
(List separately in addition to primary procedure)
(Use 33141 in conjunction with codes 33496, 33510-33536, 33542)

PACEMAKER OR PACING CARDIOVERTER-DEFIBRILLATOR

A pacemaker system includes a pulse generator containing electronics and a battery, and one or more electrodes (leads). Pulse generators are placed in a subcutaneous "pocket" created in either a subclavicular or underneath the abdominal muscles just below the ribcage.

Electrodes may be inserted through a vein (transvenous) or they may be placed on the surface of the heart (epicardial). The epicardial location of electrodes requires a thoracotomy for electrode insertion.

A single chamber pacemaker system includes a pulse generator and one electrode inserted in either the atrium or ventricle. A dual chamber pacemaker system includes a pulse generator and one electrode inserted in the right atrium and one electrode inserted in the right ventricle. In certain circumstances, an additional electrode may be required to achieve pacing of the left ventricle (bi-ventricular pacing). In this event, transvenous (cardiac vein) placement of the electrode should be separately reported using code 33224 or 33225. Epicardial placement of the electrode should be separately reported using 33202-33203.

Like a pacemaker system, a pacing cardioverter defibrillator system also includes a pulse generator and electrodes, although pacing cardioverter-defibrillators may require multiple leads, even when only a single chamber is being paced. A pacing cardioverter-defibrillator system may be inserted in a single chamber (pacing the ventricle) or in dual chambers (pacing the atrium and ventricle). These devices use a combination of antitachycardia pacing, low energy cardioversion or defibrillating shocks to treat ventricular tachycardia or ventricular fibrillation.

Pacing cardioverter-defibrillator pulse generators may be implanted in a subcutaneous infraclavicular pocket or in an abdominal pocket. Removal of a pacing cardioverter-defibrillator pulse generator requires opening of the existing subcutaneous pocket and disconnection of the pulse generator from its electrode(s). A thoracotomy (or laparotomy in the case of abdominally placed pulse generators) is not required to remove the pulse generator.

The electrodes (leads) of a pacing cardioverter-defibrillator system are positioned in the heart via the venous system (transvenously), in most circumstances. In certain circumstances, an additional electrode may be required to achieve pacing of the left ventricle (bi-ventricular pacing). In this event, transvenous (cardiac vein) placement of the electrode should be separately reported using code 33224 or 33225. Epicardial placement of the electrode should be separately reported using 33202-33203.

Electrode positioning on the epicardial surface of the heart requires thoracotomy, or thoracoscopic placement of the leads. Removal of electrode(s) may first be attempted by transvenous extraction (code 33244).

However, if transvenous extraction is unsuccessful, a thoracotomy may be required to remove the electrodes (code 33243). Use codes 33212, 33213, 33240 as appropriate in addition to the thoracotomy or endoscopic epicardial lead placement codes to report the insertion of the generator if done by the same physician during the same session.

When the "battery" of a pacemaker or pacing cardioverter-defibrillator is changed, it is actually the pulse generator that is changed. Replacement of a pulse generator should be reported with a code for removal of the pulse generator and another code for insertion of a pulse generator.

Repositioning of a pacemaker electrode, pacing cardioverter-defibrillator electrode(s), or a left ventricular pacing electrode is reported using 33215 or 33226, as appropriate. Replacement of a pacemaker electrode, pacing cardioverter-defibrillator electrode(s), of a left ventricular pacing electrode is reported using 33206-33208, 33210-33213, or 33224, as appropriate.

33202 Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach)
33203 endoscopic approach (eg, thoracoscopy, pericardioscopy)
(When epicardial lead placement is performed by the same physician at the same session as insertion of the generator, report 33202, 33203 in conjunction with 33212, 33213, as appropriate)
33206 Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial
33207 ventricular
33208 atrial and ventricular
(Codes 33206-33208 include subcutaneous insertion of the pulse generator and transvenous placement of electrode(s))
33210 Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure)
33211 Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)
33212 Insertion of pacemaker pulse generator only; with existing single lead
33213 with existing dual leads
(When epicardial lead placement is performed with insertion of generator, report 33202, 33203 in conjunction with 33212, 33213)
33214 Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)
(Do not report 33214 in conjunction with 33227-33229)
33215 Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode
33216 Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator

33217 Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator
33218 Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator
33220 Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator
33221 Insertion of pacemaker pulse generator only; with existing multiple leads
33222 Relocation of skin pocket for pacemaker
33223 Relocation of skin pocket for implantable defibrillator
33224 Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)
(When epicardial electrode placement is performed, report 33224 in conjunction with 33202, 33203)
33225 Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to primary procedure)
(Use 33225 in conjunction with 33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33221,33223, 33228, 33229, 33230, 33231, 33233, 33234, 33235, 33240, 33249, 33263, 33264)
33226 Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)
33227 Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system
33228 dual lead system
33229 multiple lead system
(Do not report 33227-33229 in conjunction with 33233)
33230 Insertion of implantable defibrillator pulse generator with existing dual leads
33231 with existing multiple leads
(Do not report 33230, 33231, 33240 in conjunction with 33241 for removal and replacement of the pacing cardioverter-defibrillator pulse generator. Use 33262-33264, as appropriate, when pulse generator replacement is indicated)
33233 Removal of permanent pacemaker pulse generator only
33234 Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular
33235 dual lead system
33236 Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular
33237 dual lead system
33238 Removal of permanent transvenous electrode(s) by thoracotomy
33240 Insertion of implantable defibrillator pulse generator only; with existing single lead
(Use 33240, as appropriate, in addition to the epicardial lead placement codes to report the insertion of the generator when done by the same physician during the same session)
33241 Removal of implantable defibrillator pulse generator only
33243 Removal of single or dual chamber implantable defibrillator electrode(s); by thoracotomy
33244 by transverse extraction
33249 Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber

33262 Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system
33263 dual lead system
33264 multiple lead system
33270 Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed
33271 Insertion of subcutaneous implantable defibrillator electrode
33272 Removal of subcutaneous implantable defibrillator electrode
33273 Repositioning of previously implanted subcutaneous implantable defibrillator electrode

ELECTROPHYSIOLOGIC OPERATIVE PROCEDURES

This family of codes describes the surgical treatment of supraventricular dysrhythmias. Tissue ablation, disruption and reconstruction can be accomplished by many methods including surgical incision or through the use of a variety of energy sources (eg, radiofrequency, cryotherapy, microwave, ultrasound, laser). If excision or isolation of the left atrial appendage by any method, including stapling, oversewing, ligation, or plication, is performed in conjunction with any of the atrial tissue ablation and reconstruction (maze) procedures (33254-33259, 33265-33266), it is considered part of the procedure.

Codes 33254-33256 are only to be reported when there is no concurrently performed procedure that requires median sternotomy or cardiopulmonary bypass.

DEFINITIONS:

Limited operative ablation and reconstruction includes:

Surgical isolation of triggers of supraventricular dysrhythmias by operative ablation that isolates the pulmonary veins or other anatomically defined triggers in the left or right atrium.

Extensive operative ablation and reconstruction includes:

1. The services included in “limited’’
2. Additional ablation of atrial tissue to eliminate sustained supraventricular dysrhythmias. This must include operative ablation that involves either the right atrium, the atrial septum, or left atrium in continuity with the atrioventricular annulus.

INCISION

33250 Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); without cardiopulmonary bypass
33251 with cardiopulmonary bypass

33254 Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)
33255 Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass
33256 with cardiopulmonary bypass
33257 Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure)
(List separately in addition to primary procedure)
33258 Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass
(List separately in addition to primary procedure)
33259 Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass
(List separately in addition to primary procedure)
33261 Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass
33263 dual lean system
33264 multiple lead system

ENDOSCOPY

33265 Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass
33266 extensive (eg, maze procedure), without cardiopulmonary bypass

SUBCUTANEOUS CARDIAC RHYTHM MONITOR

A subcutaneous cardiac rhythm monitor, also known as a cardiac event recorder or implantable/insertable loop recorder (ILR), is a subcutaneously placed device that continuously records the electrocardiographic rhythm, triggered automatically by rapid, irregular and/or slow heart rates or by the patient during a symptomatic episode. A subcutaneous cardiac rhythm monitor is placed using a small parasternal incision followed by insertion of the monitor into a small subcutaneous prepectoral pocket, followed by closure of the incision.

33285 Insertion, subcutaneous cardiac rhythm monitor, including programming
33286 Removal, subcutaneous cardiac rhythm monitor

WOUNDS OF THE HEART AND GREAT VESSELS

33300 Repair of cardiac wound; without bypass
33305 with cardiopulmonary bypass
33310 Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); without bypass
33315 with cardiopulmonary bypass
33320 Suture repair of aorta or great vessels; without shunt or cardiopulmonary bypass

33321 with shunt bypass
33322 with cardiopulmonary bypass
33330 Insertion of graft, aorta or great vessels; without shunt, or cardiopulmonary bypass
33335 with cardiopulmonary bypass

CARDIAC VALVES

33361 Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
33362 open femoral artery approach
33363 open axillary artery approach
33364 open iliac artery approach
33365 transaortic approach (eg, median sternotomy, mediastinotomy)
33366 transapical exposure (eg, left thoracotomy)
33367 cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels)
(List separately in addition to primary procedure)
33368 cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels)
(List separately in addition to primary procedure)
33369 cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery)
(List separately in addition to primary procedure)
33390 Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple (ie, valvotomy, debridement, debulking, and/or simple commissural resuspension)
33391 complex (eg, leaflet extension, leaflet resection, leaflet reconstruction, or annuloplasty)

AORTIC VALVE

33404 Construction of apical-aortic conduit
33405 Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve
33406 with allograft valve (freehand)
33410 with stentless tissue valve
33440 Replacement, aortic valve; by translocation of autologous pulmonary valve and transventricular aortic annulus enlargement of the left ventricular outflow tract with valved conduit replacement of pulmonary valve (Ross-Konno procedure)
33411 Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus
33412 with transventricular aortic annulus enlargement (Konno procedure)
33413 by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)
33414 Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract
33415 Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis
33416 Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy)

33417 Aortoplasty (gusset) for supravalvular stenosis

MITRAL VALVE

33418 Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis
33419 additional prosthesis(es) during same session (List separately in addition to code for primary procedure)
33420 Valvotomy, mitral valve; closed heart
33422 open heart, with cardiopulmonary bypass
33425 Valvuloplasty, mitral valve, with cardiopulmonary bypass;
33426 with prosthetic ring
33427 radical reconstruction, with or without ring
33430 Replacement, mitral valve, with cardiopulmonary bypass

TRICUSPID VALVE

33460 Valvectomy, tricuspid valve, with cardiopulmonary bypass;
33463 Valvuloplasty, tricuspid valve; without ring insertion
33464 with ring insertion
33465 Replacement, tricuspid valve, with cardiopulmonary bypass
33468 Tricuspid valve repositioning and plication for Ebstein anomaly

PULMONARY VALVE

(Do not report modifier –63 in conjunction with 33470)

33470 Valvotomy, pulmonary valve, closed heart; transventricular
33471 via pulmonary artery
33474 Valvotomy, pulmonary valve, open heart, with cardiopulmonary bypass
33475 Replacement, pulmonary valve
33476 Right ventricular resection for infundibular stenosis, with or without commissurotomy
33477 Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed
33478 Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection

OTHER VALVULAR PROCEDURES

33496 Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure)

CORONARY ARTERY ANOMALIES

Basic procedures include endarterectomy or angioplasty.

33500 Repair of coronary arteriovenous or arteriocardiac chamber fistula; with cardio-pulmonary bypass

33501 without cardio-pulmonary bypass
33502 Repair of anomalous coronary artery from pulmonary artery origin; by ligation
33503 by graft, without cardiopulmonary bypass
33504 by graft, with cardiopulmonary bypass
33505 with construction of intrapulmonary artery tunnel (Takeuchi procedure)
33506 by translocation from pulmonary artery to aorta
33507 Repair of anomalous (eg, intramural) aortic origin of coronary artery by unroofing or translocation

ENDOSCOPY

Surgical vascular endoscopy always includes diagnostic endoscopy.

33508 Endoscopy, surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure
(List separately in addition to primary procedure)

VENOUS GRAFTING ONLY FOR CORONARY ARTERY BYPASS

The following codes are used to report coronary artery bypass procedures using venous grafts only. These codes should NOT be used to report the performance of coronary artery bypass procedures using arterial grafts and venous grafts during the same procedure.

See 33517-33523 and 33533-33536 for reporting combined arterial-venous grafts.

Procurement of the saphenous vein graft is included in the description of the work for 33510-33516 and should not be reported as a separate service or co-surgery. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure.

To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs graft procurement, add modifier –80 to 33510-33516.

33510 Coronary artery bypass, vein only; single coronary venous graft
33511 two coronary venous grafts
33512 three coronary venous grafts
33513 four coronary venous grafts
33514 five coronary venous grafts
33516 six or more coronary venous grafts

COMBINED ARTERIAL-VENOUS GRAFTING FOR CORONARY BYPASS

The following codes are used to report coronary artery bypass procedures using venous grafts and arterial grafts during the same procedure. These codes may NOT be used alone.

To report combined arterial-venous grafts it is necessary to report two codes: 1) the appropriate combined arterial-venous graft code (33517-33523); and 2) the appropriate arterial graft code (33533-33536).

Procurement of the saphenous vein graft is included in the description of the work for 33517-33523 and should not be reported as a separate service or co-surgery. Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of an upper extremity artery, use 35600 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier -80 to 33517-33523, 33533-33536, as appropriate.

33517 Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft
(List separately in addition to primary procedure)
(Use 33517 in conjunction with 33533-33536)

33518 two venous grafts
(List separately in addition to primary procedure)
(Use 33518 in conjunction with 33533-33536)

33519 three venous grafts
(List separately in addition to primary procedure)
(Use 33519 in conjunction with 33533-33536)

33521 four venous grafts
(List separately in addition to primary procedure)
(Use 33521 in conjunction with 33533-33536)

33522 five venous grafts
(List separately in addition to primary procedure)
(Use 33522 in conjunction with 33533-33536)

33523 six or more venous grafts
(List separately in addition to primary procedure)
(Use 33523 in conjunction with 33533-33536)

33530 Reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation
(List separately in addition to primary procedure)

ARTERIAL GRAFTING FOR CORONARY ARTERY BYPASS

The following codes are used to report coronary artery bypass procedures using either arterial grafts only or a combination of arterial-venous grafts. The codes include the use of the internal mammary artery, gastroepiploic artery, epigastric artery, radial artery, and arterial conduits procured from other sites.

To report combined arterial-venous grafts it is necessary to report two codes: 1) the appropriate arterial graft code (33533-33536); and 2) the appropriate combined arterial-venous graft code (33517-33523).

Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 35600 in addition

to the bypass procedure. To report harvesting of an upper extremity vein, use 33500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 33572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier -80 to 33517-33523, 33533-33536 as appropriate.

33533 Coronary artery bypass, using arterial graft(s); single arterial graft
33534 two coronary arterial grafts
33535 three coronary arterial grafts
33536 four or more coronary arterial grafts
33542 Myocardial resection (eg, ventricular aneurysmectomy)
33545 Repair of postinfarction ventricular septal defect, with or without myocardial resection
33548 Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, DOR procedures)
(Do not report 33548 in conjunction with 32551, 33210, 33211, 33310, 33315)

CORONARY ENDARTERECTOMY

33572 Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel
(List separately in addition to primary procedure)
(Use 33572 in conjunction with 33510-33516, 33533-33536)

SINGLE VENTRICLE AND OTHER COMPLEX CARDIAC ANOMALIES

(Do not report modifier –63 in conjunction with 33610, 33611 or 33619)

33600 Closure of atrioventricular valve (mitral or tricuspid) by suture or patch
33602 Closure of semilunar valve (aortic or pulmonary) by suture or patch
33606 Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure)
33608 Repair of complex cardiac anomaly other than pulmonary atresia with ventricular septal defect by construction or replacement of conduit from right or left ventricle to pulmonary artery
33610 Repair of complex cardiac anomalies (eg, single ventricle with subaortic obstruction) by surgical enlargement of ventricular septal defect
33611 Repair of double outlet right ventricle with intraventricular tunnel repair;
33612 with repair of right ventricular outflow tract obstruction
33615 Repair of complex cardiac anomalies (eg, tricuspid atresia) by closure of atrial septal defect and anastomosis of atria or vena cava to pulmonary artery (simple Fontan procedure)
33617 Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure
33619 Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)
33620 Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)
33621 Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)
33622 Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia,

creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)
(Do not report 33622 in conjunction with 33619, 33767, 33822, 33840, 33845, 33851, 33853, 33917)

SEPTAL DEFECT

33641 Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch
33645 Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage
33647 Repair of atrial septal defect and ventricular septal defect, with direct or patch closure
33660 Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair

33665 Repair of intermediate or transitional atrioventricular canal, with or without atrioventricular valve repair
33670 Repair of complete atrioventricular canal, with or without prosthetic valve
33675 Closure of multiple ventricular septal defects;
33676 with pulmonary valvotomy or infundibular resection (acyanotic)
33677 with removal of pulmonary artery band, with or without gusset
33681 Closure of single ventricular septal defect, with or without patch;
33684 with pulmonary valvotomy or infundibular resection (acyanotic)
33688 with removal of pulmonary artery band, with or without gusset
33690 Banding of pulmonary artery
33692 Complete repair tetralogy of Fallot without pulmonary atresia;
33694 with transannular patch
33697 Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect

SINUS OF VALSALVA

33702 Repair sinus of Valsalva fistula, with cardiopulmonary bypass;
33710 with repair of ventricular septal defect
33720 Repair sinus of Valsalva aneurysm, with cardiopulmonary bypass
33722 Closure of aortico-left ventricular tunnel

VENOUS ANOMALIES

(Do not report modifier –63 in conjunction with 33730, 33732)

33724 Repair of isolated partial anomalous pulmonary venous return (eg, scimitar syndrome)
33726 Repair of pulmonary venous stenosis
(Do not report 33724, 33726 in conjunction with 32551, 33210, 33211)
33730 Complete repair of anomalous venous return (supracardiac, intracardiac, or infracardiac types)
33732 Repair of cor triatriatum or supravalvular mitral ring by resection of left atrial membrane

SHUNTING PROCEDURES

(Do not report modifier –63 in conjunction with 33735, 33736, 33750, 33755, 33762)

33735 Atrial septectomy or septostomy; closed heart (Blalock-Hanlon type operation)
33736 open heart with cardiopulmonary bypass
33737 open heart, with inflow occlusion
33741 Transcatheter atrial septostomy (TAS) congenital cardiac anomalities to create effective atrial flow, including all imagin guidance by the proceduralist, when performed, any method (eg, Rashkind, Sang-Park, balloon, cutting balloon, blade)
33745 Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when preformed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt
33746 each additional intracardiac shunt location (List separately in addition to code for primary procedure)
33750 Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation)
33755 ascending aorta to pulmonary artery (Waterston type operation)
33762 descending aorta to pulmonary artery (Potts-Smith type operation)
33764 central, with prosthetic graft
33766 superior vena cava to pulmonary artery for flow to one lung (classical Glenn procedure)
33767 superior vena cava to pulmonary artery for flow to both lungs (bidirectional Glenn procedure)
33768 Anastomosis, cavopulmonary, second superior vena cava
(List separately in addition to primary procedure)

TRANSPOSITION OF THE GREAT VESSELS

33770 Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect
33771 with surgical enlargement of ventricular septal defect
33774 Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass;
33775 with removal of pulmonary band
33776 with closure of ventricular septal defect
33777 with repair of subpulmonic obstruction
33778 Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type)
(Do not report modifier –63 in conjunction with 33778)
33779 with removal of pulmonary band
33780 with closure of ventricular septal defect
33781 with repair of subpulmonic obstruction

33782 Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation
33783 with reimplantation of 1 or both coronary ostia

TRUNCUS ARTERIOSUS

33786 Total repair, truncus arteriosus (Rastelli type operation)
(Do not report modifier –63 in conjunction with 33786)
33788 Reimplantation of an anomalous pulmonary artery

AORTIC ANOMALIES

33800 Aortic suspension (aortopexy) for tracheal decompression (eg, for tracheomalacia) (separate procedure)
33802 Division of aberrant vessel (vascular ring);
33803 with reanastomosis
33813 Obliteration of aortopulmonary septal defect; without cardiopulmonary bypass
33814 with cardiopulmonary bypass
33820 Repair of patent ductus arteriosus; by ligation
33822 by division, under 18 years
33824 by division, 18 years and older
33840 Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis
33845 with graft
33851 repair using either left subclavian artery or prosthetic material as gusset for enlargement
33852 Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass
33853 with cardiopulmonary bypass

THORACIC AORTIC ANEURYSM

33858 Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection
33859 for aortic disease other than dissection (eg, aneurysm)
33863 with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)
33864 with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)
33866 Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)
33871 Transverse aortic arch graft, with cardiopulmonary bypass, with profound hypothermia, total circulatory arrest and isolated cerebral perfusion with reimplantation of arch vessel(s) (eg, island pedicle or individual arch vessel reimplantation)
33875 Descending thoracic aorta graft, with or without bypass

33877 Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass

ENDOVASCULAR REPAIR OF DESCENDING THORACIC AORTA

Codes 33880-33891 represent a family of procedures to report placement of an endovascular graft for repair of the descending thoracic aorta. These codes include all device introduction, manipulation, positioning, and deployment. All balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment, are not separately reportable.

For fluoroscopic guidance in conjunction with endovascular repair of the thoracic aorta, see codes 75956-75959 as appropriate. Codes 75956 and 75957 include all angiography of the thoracic aorta and its branches for diagnostic imaging prior to deployment of the primary endovascular devices (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff). Code 75958 includes the analogous services for placement of each proximal thoracic endovascular extension. Code 75959 includes the analogous services for placement of a distal thoracic endovascular extension(s) placed during a procedure after the primary repair.

Other interventional procedures performed at the time of endovascular repair of the descending thoracic aorta should be additionally reported (eg, innominate, carotid, subclavian, visceral, or iliac artery transluminal angioplasty or stenting, arterial embolization, intravascular ultrasound) when performed before or after deployment of the aortic prostheses.

33880 Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin

33881 not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin

33883 Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension
(Do not report 33881, 33883 when extension placement converts repair to cover left subclavian origin. use only 33880)

33884 each additional proximal extension
(List separately in addition to primary procedure)
(Use 33884 in conjunction with 33883)

33886 Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta
(Do not report 33886 in conjunction with 33880, 33881)
(Report 33886 once, regardless of number of modules deployed)

33889 Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral
(Do not report 33889 in conjunction with 35694)

33891 Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision
(Do not report 33891 in conjunction with 35509, 35601)

PULMONARY ARTERY

33910 Pulmonary artery embolectomy; with cardiopulmonary bypass
33915 without cardiopulmonary bypass
33916 Pulmonary endarterectomy with or without embolectomy, with cardiopulmonary bypass
33917 Repair of pulmonary artery stenosis by reconstruction with patch or graft
33920 Repair of pulmonary atresia with ventricular septal defect, by construction or replacement of conduit from right or left ventricle to pulmonary artery
33922 Transection of pulmonary artery with cardiopulmonary bypass
(Do not report modifier –63 in conjunction with 33922)
33924 Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure
(List separately in addition to primary procedure)
33925 Repair of pulmonary artery arborization anomalies by unifocalization; without cardiopulmonary bypass
33926 with cardiopulmonary bypass
(Do not report 33925, 33926 in conjunction with 33697)

HEART/LUNG TRANSPLANTATION

33927 Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy
33928 Removal and replacement of total replacement heart system (artificial heart)
33929 Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)
33935 Heart-lung transplant with recipient cardiectomy-pneumonectomy
33945 Heart transplant, with or without recipient cardiectomy

EXTRACORPOREAL MEMBRANE OXYGENATION or EXTRACORPOREAL LIFE SUPPORT SERVICES

33946 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous
33947 initiation veno-arterial
33948 daily management, each day, veno-venous
33949 daily management, each day, veno-arterial
33951 insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)
33952 insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)
33953 insertion of peripheral (arterial and/or venous) cannula(e), open,

birth through 5 years of age
33954 insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older
33955 insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age
33956 insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older
33957 reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)
33958 reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)
33959 reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance when performed)
33962 reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)
33963 reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed
33964 reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)
33965 removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age
33966 removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older
33969 removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age
33984 removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older
33985 removal of central cannula(e), by sternotomy or thoracotomy, birth through 5 years of age
33986 removal of central cannula(e), by sternotomy or thoracotomy, 6 years and older
33987 Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure
33988 Insertion of left heart vent by thoracic incision (eg, sternotomy/ thoracotomy) for ECMO/ECLS
33989 Removal of left heart vent by thoracic incision (eg, sternotomy/ thoracotomy) for ECMO/ECLS

CARDIAC ASSIST

33967 Insertion of intra-aortic balloon assist device, percutaneous
33968 Removal of intra-aortic balloon assist device, percutaneous
33970 Insertion of intra-aortic balloon assist device through the femoral artery, open approach
33971 Removal of intra-aortic balloon assist device including repair of femoral artery, with or without graft
33973 Insertion of intra-aortic balloon assist device through the ascending aorta
33974 Removal of intra-aortic balloon assist device from the ascending aorta, including repair of the ascending aorta, with or without graft
33975 Insertion of ventricular assist device; extracorporeal, single ventricle
33976 extracorporeal, biventricular
33977 Removal of ventricular assist device; extracorporeal, single ventricle
33978 extracorporeal, biventricular
33979 Insertion of ventricular assist device, implantable intracorporeal, single ventricle
33980 Removal of ventricular assist device, implantable intracorporeal, single ventricle
33981 Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump
33982 Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass
33983 with cardiopulmonary bypass
33995 Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only
33990 left heart, arterial access only
33991 left heart, both arterial and venous access, with transseptal puncture
33992 Removal of percutaneous left heart ventricular assist device, arterial or arterial and venous cannula(s), at separate and distinct session from insertion
33997 Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion.
33993 Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion

OTHER PROCEDURES

33999 Unlisted procedure, cardiac surgery

ARTERIES AND VEINS

Primary vascular procedure listings include establishing both inflow and outflow by whatever procedures necessary. Also included is that portion of the operative arteriogram performed by the surgeon, as indicated. Sympathectomy, when done, is included in the listed aortic procedures. For unlisted vascular procedure, use 37799.

EMBOLECTOMY/THROMBECTOMY

ARTERIAL, WITH OR WITHOUT CATHETER

34001 Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision

34051 innominate, subclavian artery, by thoracic incision
34101 axillary, brachial, innominate, subclavian artery, by arm incision
34111 radial or u1nar artery, by arm incision
34151 renal, celiac, mesentery, aortoiliac artery, by abdominal incision
34201 femoropopliteal, aortoiliac artery, by leg incision
34203 popliteal-tibio-peroneal, by leg incision

VENOUS, DIRECT OR WITH CATHETER

34401 Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision
34421 vena cava, iliac, femoropopliteal vein, by leg incision
34451 vena cava, iliac, femoropopliteal vein, by abdominal and leg incision
34471 subclavian vein, by neck incision
34490 axillary and subclavian vein, by arm incision

VENOUS RECONSTRUCTION

34501 Valvuloplasty, femoral vein
34502 Reconstruction of vena cava, any method
34510 Venous valve transposition, any vein donor
34520 Cross-over vein graft to venous system
34530 Saphenopopliteal vein anastomosis

ENDOVASCULAR REPAIR OF ABDOMINAL AORTA AND/OR ILIAC ARTERIES

34701 Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer)
34702 for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)
34703 Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer)
34704 for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)
34705 Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the

renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)

34706 for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)

34707 Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation,and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm,pseudoaneurysm,dissection,arteriovenous malformation)

34708 for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)

34717 Endovascular repair of iliac artery at the time of aortoiliac artery endograft placement by development of an iliac branched endograft including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting when performed, for rupture or other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer, traumatic disruption), unilateral (List separately in addition to code for primary procedure)

34709 Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)

34718 Endovascular repair of iliac artery, not associated with placement of an aorto-iliac artery endograft at the same session, by deployment of an iliac branched endograft, including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer), unilateral

34710 Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; initial vessl treated

34711 each additional vessel treated (List separately in addition to code for primary procedure)

34712 Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation
34713 Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French of larger), including ultrasound guidance, when performed, unilateral (List separately in additional to code for primary procedure)
34714 Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)
34715 Open axillary/subclavian exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)
34716 Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)
34808 Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)
34812 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)
34813 Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to primary procedure)
(Use 34813 in conjunction with code 34812)
34820 Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)
34830 Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis
34831 aorto-bi-iliac prosthesis
34832 aorto-bifemoral prosthesis
34833 Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)
34834 Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)

34715 Open axillary/subclavian exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)
34716 Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)

FENESTRATED ENDOVASCULAR REPAIR of the VISCERAL and INFRARENAL AORTA

34841 Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneuysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a

fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprostheses (superior mesenteric, celiac or renal artery)

34842 including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

34843 including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

34844 including four or more visceral artery endoprosthesis (superior mesenteric, celiac and/or renal artery[s])

34845 Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneuysm, dissection, penetrating ulcer, intramual hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)

34846 including two visceral artery endoprosthesis (superior mesenteric, celiac or renal artery[s])

34847 including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

34848 including four or more visceral artery endoprosthesis (superior mesenteric, celiac and/or renal artery[s])

DIRECT REPAIR OF ANEURYSM OR EXCISION (PARTIAL OR TOTAL) AND GRAFT INSERTION FOR ANEURSYM, PSEUDOANEURYSM, RUPTURED ANEURYSM, AND ASSOCIATED OCCLUSIVE DISEASE

Procedures 35001 - 35152 include preparation of artery for anastomosis including endarterectomy.

35001 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, carotid, subclavian artery, by neck incision

35002 for ruptured aneurysm, carotid, subclavian artery, by neck incision

35005 for aneurysm, pseudoaneurysm, and associated occlusive disease, vertebral artery

35011 for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision

35013 for ruptured aneurysm, axillary-brachial artery, by arm incision

35021 for aneurysm, pseudoaneurysm, and associated occlusive disease, innominate, subclavian artery, by thoracic incision

35022 for ruptured aneurysm, innominate, subclavian artery, by thoracic incision

35045 for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery

35081 for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta

35082 for ruptured aneurysm, abdominal aorta

35091 for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)

35092 for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)

35102 for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)
35103 for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)
35111 for aneurysm, pseudoaneurysm, and associated occlusive disease, splenic artery
35112 for ruptured aneurysm, splenic artery
35121 for aneurysm, pseudoaneurysm, and associated occlusive disease, hepatic, celiac, renal or mesenteric artery
35122 for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery
35131 for aneurysm, pseudoaneurysm, and associated occlusive disease, iliac artery (common, hypogastric, external)
35132 for ruptured aneurysm, iliac artery (common, hypogastric, external)
35141 for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)
35142 for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral)
35151 for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery
35152 for ruptured aneurysm, popliteal artery

REPAIR ARTERIOVENOUS FISTULA

35180 Repair, congenital arteriovenous fistula; head and neck
35182 thorax and abdomen
35184 extremities
35188 Repair, acquired or traumatic arteriovenous fistula; head and neck
35189 thorax and abdomen
35190 extremities

REPAIR BLOOD VESSEL OTHER THAN FOR FISTULA, WITH OR WITHOUT PATCH ANGIOPLASTY

35201 Repair blood vessels, direct; neck
35206 upper extremity
35207 hand, finger
35211 intrathoracic, with bypass
35216 intrathoracic, without bypass
35221 intra-abdominal
35226 lower extremity
35231 Repair blood vessel with vein graft; neck
35236 upper extremity
35241 intrathoracic, with bypass
35246 intrathoracic, without bypass
35251 intra-abdominal
35256 lower extremity
35261 Repair blood vessel with graft other than vein; neck
35266 upper extremity
35271 intrathoracic, with bypass

35276 intrathoracic, without bypass
35281 intra-abdominal
35286 lower extremity

THROMBOENDARTERECTOMY

(35301-35372 include harvest of saphenous or upper extremity vein when performed)

35301 Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision
35302 superficial femoral artery
35303 popliteal artery
(Do not report 35302, 35303 in conjunction with 35500)
35304 tibioperoneal trunk artery
35305 tibial or peroneal artery, initial vessel
35306 each additional tibial or peroneal artery
(List separately in addition to primary procedure)
(Use 35306 in conjunction with 35305)
(Do not report 35304, 35305, 35306 in conjunction with 35500)
35311 subclavian, innominate, by thoracic incision
35321 axillary-brachial
35331 abdominal aorta
35341 mesenteric, celiac, or renal
35351 iliac
35355 iliofemoral
35361 combined aortoiliac
35363 combined aortoiliofemoral
35371 common femoral
35372 deep (profunda) femoral
35390 Reoperation, carotid, thromboendarterectomy, more than one month after original operation
(List separately in addition to primary procedure)
(Use 35390 in conjunction with 35301)

ANGIOSCOPY

35400 Angioscopy (non-coronary vessels or grafts) during therapeutic intervention
(List separately in addition to primary procedure)

TRANSLUMINAL ANGIOPLASTY

OPEN

PERCUTANEOUS

BYPASS GRAFT

VEIN

Procurement of the saphenous vein graft is included in the description of the work for 35501-35587 and should not be reported as a separate service or co-surgery. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, use 35572 in addition to the bypass procedure. To report harvesting and construction of an autogenous composite graft of two segments from two distant locations, report 35682 in addition to the bypass procedure, for autogenous composite of three or more segments from distant sites, report 35683.

35500 Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure
(List separately in addition to primary procedure)
(Use 35500 in conjunction with 33510-33536, 35556, 35566, 35571, 35583-35587)
35501 Bypass graft, with vein; common carotid-ipsilateral internal carotid
35506 carotid-subclavian or subclavian-carotid
35508 carotid-vertebral
35509 carotid-contralateral carotid
35510 carotid-brachial
35511 subclavian-subclavian
35512 subclavian-brachial
35515 subclavian-vertebral
35516 subclavian-axillary
35518 axillary-axillary
35521 axillary-femoral
35522 axillary-brachial
35523 brachial-ulnar or -radial
(Do not report 35523 in conjunction with 35206, 35500, 35525, 36838)
35525 brachial-brachial
35526 aortosubclavian, aortoinnominate, or aortocarotid
35531 aortoceliac or aortomesenteric
35533 axillary-femoral-femoral
35535 hepatorenal
(Do not report 35535 in conjunction with 35221, 35251, 35281, 35500, 35536, 35560, 35631, 35636)
35536 splenorenal
35537 aortoiliac
(Do not report 35537 in conjunction with 35538)
35538 aortobi-iliac
(Do not report 35538 in conjunction with 35537)
35539 aortofemoral
(Do not report 35539 in conjunction with 35540)
35540 aortobifemoral
(Do not report 35540 in conjunction with 35539)
35556 femoral-popliteal
35558 femoral-femoral

35560 aortorenal
35563 ilioiliac
35565 iliofemoral
35566 femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels
35570 tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial
(Do not report 35570 in conjunction with 35256, 35286)
35571 popliteal-tibial, -peroneal artery or other distal vessels
35572 Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery)
(List separately in addition to primary procedure)
(Use 35572 in conjunction with code 33510-33516, 33517-33523, 33523, 33533-33536, 34502, 34520, 35001, 35002, 35011-35022, 35102, 35103, 35121-35152, 35231-35256, 35501-35587, 35879-35907)
(For bilateral procedure, use modifier -50)

IN SITU VEIN

35583 In-situ vein bypass; femoral-popliteal
35585 femoral-anterior tibial, posterior tibial, or peroneal artery
35587 popliteal-tibial, perineal

OTHER THAN VEIN

35600 Harvest of upper extremity artery, one segment, for coronary artery bypass procedure
(List separately in addition to primary procedure)
(Use 35600 in conjunction with 33533-33536)
35601 Bypass graft, with other than vein; common carotid-ipsilateral internal carotid
35606 carotid-subclavian
35612 subclavian-subclavian
35616 subclavian-axillary
35621 axillary-femoral
35623 axillary-popliteal or -tibial
35626 aortosubclavian, aortoinnominate, or aortocarotid
35631 aortoceliac, aortomesenteric, aortorenal
35632 ilio-celiac
(Do not report 35632 in conjunction with 35221, 35251, 35281, 35531, 35631)
35633 ilio-mesenteric
(Do not report 35633 in conjunction with 35221, 35251, 35281, 35531, 35631)
35634 iliorenal
(Do not report 35634 in conjunction with 35221, 35251, 35281, 35560, 35536, 35631)
35636 splenorenal (splenic to renal arterial anastomosis)
35637 aortoiliac
(Do not report 35637 in conjunction with 35638, 35646)
35638 aortobi-iliac
(Do not report 35638 in conjunction with 35637, 35646)
35642 carotid-vertebral

35645 subclavian-vertebral
35646 aortobifemoral
35647 aortofemoral
35650 axillary-axillary
35654 axillary-femoral-femoral
35656 femoral-popliteal
35661 femoral-femoral
35663 ilioiliac
35665 iliofemoral
35666 femoral-anterior tibial, posterior tibial, or peroneal artery
35671 popliteal-tibial, or -peroneal artery

COMPOSITE GRAFTS

Codes 35682-35683 are used to report harvest and anastomosis of multiple vein segments from distant sites for use as arterial bypass graft conduits. These codes are intended for use when the two or more vein segments are harvested from a limb other than that undergoing bypass. Add-on codes 35682 and 35683 are reported in addition to bypass graft codes 35556, 35566, 35571, 35583-35587, as appropriate.

35681 Bypass graft; composite, prosthetic and vein
(List separately in addition to primary procedure)
35682 autogenous composite, two segments of veins from two locations
(List separately in addition to primary procedure)
35683 autogenous composite, three or more segments of vein from two or more locations
(List separately in addition to primary procedure)
(Do not report 35681-35683 in addition to each other.)

ADJUVANT TECHNIQUES

Adjuvant (additional) technique(s) may be required at the time a bypass graft is created to improve patency of the lower extremity autogenous or synthetic bypass graft (eg, femoral-popliteal, femoral-tibial, or popliteal-tibial arteries). Code 35685 should be reported in addition to the primary synthetic bypass graft procedure, when an interposition of venous tissue (vein patch or cuff) is placed at the anastomosis between the synthetic bypass conduit and the involved artery (includes harvest).

Code 35686 should be reported in addition to the primary bypass graft procedure, when autogenous vein is used to create a fistula between the tibial or peroneal artery and vein at or beyond the distal bypass anastomosis site of the involved artery.

35685 Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit
(List separately in addition to primary procedure)
(Use 35685 in conjunction with codes 35656, 35666, or 35671)

35686 Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis)
(List separately in addition to primary procedure)

(Use 35686 in conjunction with codes 35556, 35566, 35571, 35583-35587, 35623, 35656, 35666, 35671)

ARTERIAL TRANSPOSITION

35691 Transposition and/or reimplantation; vertebral to carotid artery
35693 vertebral to subclavian artery
35694 subclavian to carotid artery
35695 carotid to subclavian artery
35697 Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery
(List separately in addition to primary procedure)
(Do not report 35697 in conjunction with 33877)

EXCISION, EXPLORATION, REPAIR, REVISION

35700 Reoperation, femoral-popliteal or femoral (popliteal) -anterior tibial, posterior tibial, peroneal artery or other distal vessels, more than one month after original operation
(List separately in addition to primary procedure)
(Use 35700 in conjunction with 35556, 35566, 35571, 35583, 35585, 35587, 35656, 35666, 35671)
35701 Exploration not followed by surgical repair, artery; neck (eg, carotid, subclavian)
35702 upper extremity (eg, axillary, brachial, radial, ulnar)
35703 lower extremity (eg, common femoral, deep femoral, superficial femoral, popliteal, tibial, peroneal)
35800 Exploration for postoperative hemorrhage, thrombosis or infection; neck
35820 chest
35840 abdomen
35860 extremity
35870 Repair of graft-enteric fistula
35875 Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula);
35876 with revision of arterial or venous graft
Codes 35879 and 35881 describe open revision of graft-threatening stenoses of lower extremity arterial bypass graft(s) (previously constructed with autogenous vein conduit) using vein patch angioplasty or segmental vein interposition techniques.
35879 Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty
35881 with segmental vein interposition
35883 Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg, Dacron, ePTFE, bovine pericardium)
(For bilateral procedure, use modifier -50)
(Do not report 35883 in conjunction with 35700, 35875, 35876, 35884)
35884 with autogenous vein patch graft
(For bilateral procedure, use modifier -50)
(Do not report 35884 in conjunction with 35700, 35875, 35876, 35883)
35901 Excision of infected graft; neck
35903 extremity

35905 thorax
35907 abdomen

VASCULAR INJECTION PROCEDURES

Listed services for injection procedures include necessary local anesthesia introduction of needles or catheter, injection of contrast media with or without automatic power injection, and/or necessary pre- and postinjection care specifically related to the injection procedure.

Catheters, drugs, and contrast media are not included in the listed service for the injection procedures.

Selective vascular catheterization should be coded to include introduction all lesser order selective catheterization used in the approach (eg, the description for a selective right middle cerebral artery catheterization includes the introduction and placement catheterization of the right common and internal carotid arteries).

Additional second and/or third order arterial catheterization within the same family of arteries or veins supplied by a single first order vessel should be expressed by 36012, 36218 or 36248. Additional first order or higher catheterization in vascular families supplied by a first order vessel different from a previously selected and coded family should be separately coded using the conventions described above.

INTRAVENOUS

An intracatheter is a sheathed combination of needle and short catheter.

36000 Introduction of needle or intracatheter, vein
(For radiological vascular injection procedure not otherwise listed)
36002 Injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm
(Do not report 36002 for vascular sealant of an arteriotomy site)
36005 Injection procedure for extremity venography (including introduction of needle or intracatheter)
36010 Introduction of catheter, superior or inferior vena cava
36011 Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)
36012 second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)
36013 Introduction of catheter, right heart or main pulmonary artery
36014 Selective catheter placement, left or right pulmonary artery
36015 Selective catheter placement, segmental or subsegmental pulmonary artery

INTRA ARTERIAL---INTRA -AORTIC

36100 Introduction of needle or intracatheter, carotid or vertebral artery
36140 Introduction of needle or intracatheter, upper or lower extremity artery
36160 Introduction of needle or intracatheter, aortic, translumbar
36200 Introduction of catheter, aorta
36215 Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family

36216 initial second order thoracic or brachiocephalic branch, within a vascular family
36217 initial third order or more selective thoracic or brachiocephalic branch, within a vascular family
36218 additional second order, third order and beyond, thoracic or brachiocephalic branch, within a vascular family
(List in addition to code for initial second or third order vessel as appropriate)
(Use 36218 in conjunction with 36216, 36217)
36221 Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

(Do not report 36221 with 36222-36226)
36222 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
36223 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
36224 Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
36225 Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
36226 Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
36227 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation
(List separately in addition to primary procedure)
(Use 36227 in conjunction with 36222, 36223, or 36224)
36228 Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery)
(List separately in addition to primary procedure)
(Use 36228 in conjunction with 36224 or 36226)
(Do not report 36228 more than twice per side)
36245 Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family

36246 initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family
36247 initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family
36248 additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family
(List in addition to code for initial second or third order vessel as appropriate)
(Use 36248 in conjunction with 36246, 36247)
36251 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), 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
36252 bilateral
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, 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
36260 Insertion of implantable intra-arterial infusion pump (eg, for chemotherapy of liver)
36261 Revision of implanted intra-arterial infusion pump
36262 Removal of implanted intra-arterial infusion pump
36299 Unlisted procedure, vascular injection

VENOUS

Venipuncture, needle or catheter for diagnostic study or intravenous therapy, percutaneous. These codes are also used to report the therapy as specified. For collection of a specimen from a completely implantable venous access device, use 36591.

(Do not report modifier –63 in conjunction with 36420, 36450, 36460, 36510)

36400 Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein
36405 scalp vein
36406 other vein
36410 Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36420 Venipuncture, cutdown; younger than age 1 year
36425 age 1 or over (Not to be used for routine venipuncture)
36430 Transfusion, blood or blood components

36440 Push transfusion, blood, 2 years or younger
36450 Exchange transfusion, blood; newborn
36455 other than newborn
36456 Partial exchange transfusion, blood, plasma or crystalloid necessitating the skill of a physician or other qualified healthcare professional, newborn
36460 Transfusion, intrauterine, fetal
36468 Injection(s) of sclerosant for spider veins (telangiectasia); limb or trunk
36470 Injection of sclerosant; single incompetent vein (other than telangiectasia)
36471 multiple incompetent veins (other than telangiectasia), same leg
36465 Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)
36466 multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg
36475 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476 subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
(Use 36476 in conjunction with 36475)
36478 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479 subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
(Use 36479 in conjunction with 36478)
36478, 36479 are an alternative to standard open stripping and ligation procedure, covered for refractory leg ulcers due to saphenous vein incompetence, or recurrent or significant bleeding from a varicosity.
36481 Percutaneous portal vein catheterization by any method
36500 Venous catheterization for selective organ blood sampling
36510 Catheterization of umbilical vein for diagnosis or therapy, newborn
36511 Therapeutic apheresis; for white blood cells
36512 for red blood cells
36513 for platelets
36514 for plasma pheresis
36516 with extracorporeal immunoadsorption, selective absorption or selective filtration and plasma reinfusion
36522 Photopheresis, extracorporeal

CENTRAL VENOUS ACCESS PROCEDURES

To qualify as a central venous access catheter or device, the tip of the catheter/device must terminate in the subclavian, brachiocephalic (innominate) or iliac veins, the superior or inferior vena cava, or the right atrium. The venous access device may be either centrally inserted (jugular, subclavian, femoral vein or inferior vena cava catheter entry site) or peripherally inserted (eg, basilic or cephalic vein).

The device may be accessed for use either via exposed catheter (external to the skin), via a subcutaneous port or via a subcutaneous pump.

The procedures involving these types of devices fall into five categories:

1) ***Insertion*** (placement of catheter through a newly established venous access)
2) ***Repair*** (fixing device without replacement of either catheter or port/pump, other than pharmacologic or mechanical correction of intracatheter or pericatheter occlusion (see 36595 or 36596))
3) ***Partial replacement*** of only the catheter component associated with a port/pump device, but not entire device
4) ***Complete replacement*** of entire device via same venous access site (complete exchange)
5) ***Removal*** of entire device.

There is no coding distinction between venous access achieved percutaneously versus by cutdown or based on catheter size.

For the repair, partial (catheter only) replacement, complete replacement, or removal of both catheters (placed from separate venous access sites) of a multi-catheter device, with or without subcutaneous ports/pumps, use the appropriate code describing the service with a frequency of two.

If an existing central venous access device is removed and a new one placed via a separate venous access site, appropriate codes for both procedures (removal of old, if code exists, and insertion of new device) should be reported.

When imaging is used for these procedures, either for gaining access to the venous entry site or for manipulating the catheter into final central position, use 76937, 77001.

INSERTION OF CENTRAL VENOUS ACCESS DEVICE

36555 Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age
36556 age 5 years or older
36557 Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age
36558 age 5 years or older
36560 Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; under 5 years of age
36561 age 5 years or older
36563 Insertion of tunneled centrally inserted central venous access device with subcutaneous pump
36565 Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)
36566 with subcutaneous port(s)
36568 Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age
36569 age 5 years or older

36572 Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age
36573 age 5 years or older
36570 Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age
36571 age 5 years or older

REPAIR OF CENTRAL VENOUS ACCESS DEVICE

36575 Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site
36576 Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site

PARTIAL REPLACEMENT OF CENTRAL VENOUS ACCESS DEVICE (CATHETER ONLY)

36578 Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site

COMPLETE REPLACEMENT OF CENTRAL VENOUS ACCESS DEVICE THROUGH SAME VENOUS ACCESS SITE

36580 Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36581 Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36582 Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access
36583 Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access
36584 Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretration required to perform the replacement
36585 Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access

REMOVAL OF CENTRAL VENOUS ACCESS DEVICE

36589 Removal of tunneled central venous catheter, without subcutaneous port or pump
36590 Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion
(Do not report 36589 or 36590 for removal of non-tunneled central venous catheters)

OTHER CENTRAL VENOUS ACCESS PROCEDURES

36591 Collection of blood specimen from a completely implantable venous access device
(Do not report 36591 in conjunction with any other service)
36593 Declotting by thrombolytic agent of implanted vascular access device or catheter
36595 Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access
(Do not report 36595 in conjunction with 36593)
36596 Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen
(Do not report 36596 in conjunction with 36593)
36597 Repositioning of previously placed central venous catheter under fluoroscopic guidance
36598 Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report
(Do not report 36598 in conjunction with 36595, 36596)
(Do not report 36598 in conjunction with 76000)

ARTERIAL

36600 Arterial puncture, withdrawal of blood for diagnosis
36620 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
36625 cutdown
36640 Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown
(See also 96420-96425)
36660 Catheterization, umbilical artery, newborn, for diagnosis or therapy
(Do not report modifier 63 in conjunction with 36660)

INTRAOSSEOUS

36680 Placement of needle for intraosseous infusion

HEMODIALYSIS ACCESS, INTERVASCULAR CANNULIZATION FOR EXTRACORPOREAL CIRCULATION, OR SHUNT INSERTION

36800 Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein
36810 arteriovenous, external (Scribner type)
36815 arteriovenous, external revision or closure
36818 Arteriovenous anastomosis, open; by upper arm cephalic vein transposition
(Do not report 36818 in conjunction with 36819, 36820, 36821, 36830 during a unilateral upper extremity procedure. For bilateral upper extremity open arteriovenous anastomoses performed at the same operative session,
use modifier -50)
36819 by upper arm basilic vein transposition

(Do not report 36819 in conjunction with 36818, 36820, 36821, 36830 during a unilateral upper extremity procedure. For bilateral upper extremity open arteriovenous anastomoses performed at the same operative session, use modifier -50)

36820 by forearm vein transposition

36821 direct, any site (eg. Cimino type) (separate procedure)

36823 Insertion of arterial and venous cannula(s) for isolated extracorporeal circulation including regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy and venotomy sites
(36823 includes chemotherapy perfusion supported by a membrane oxygenator/perfusion pump. Do not report 96409-96425 in conjunction with 36823)

36825 Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft

36830 nonautogenous graft (eg, biological collagen, thermoplastic graft)

36831 Thrombectomy, open, arteriovenous fistula without revision, autogenous or non-autogenous dialysis graft (separate procedure)

36832 Revision, open, arteriovenous fistula; without thrombectomy, autogenous or non-autogenous dialysis graft (separate procedure)

36833 with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)

36835 Insertion of Thomas shunt (separate procedure)

36838 Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)
(Do not report 36838 in conjunction with 35512, 35522, 36832, 37607, 37618)

36860 External cannula declotting (separate procedure); without balloon catheter

36861 with balloon catheter

DIALYSIS CIRCUIT

36901 Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis cicuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;

36902 with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty

36903 with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment

36904 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);

36905 with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty

36906 with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment

36907 Transluminal balloon angioplasty, central dialysis segment, performed though dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty
(List separately in addition to code for primary procedure)

36908 Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment
(List separately in addition to code for primary procedure)

36909 Dialysis cicuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention
(List separately in addition to code for primary procedure)

PORTAL DECOMPRESSION PROCEDURES

37140 Venous anastomosis, open; portocaval

37145 renoportal

37160 caval mesenteric

37180 splenorenal, proximal

37181 splenorenal, distal (selective decompression of esophagogastric varices, any technique)

37182 Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation
(Do not report 75885 or 75887 in conjunction with 37182)

37183 Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilation, stent placement and all associated imaging guidance and documentation)
(Do not report 75885 or 75887 in conjunction with code 37183)

TRANSCATHETER PROCEDURES

Codes for catheter placement and the radiologic supervision and interpretation should also be reported, in addition to the code(s) for the therapeutic aspect of the procedure.

Mechanical thrombectomy code(s) for catheter placement(s), diagnostic studies, and other percutaneous interventions (eg, transluminal balloon angioplasty, stent placement) provided are separately reportable.

Codes 37184-37188 specifically include intraprocedural fluoroscopic radiological supervision and interpretation services for guidance of the procedure.

Intraprocedural injection(s) of a thrombolytic agent is an included service and not separately reportable in conjunction with mechanical thrombectomy. However, subsequent or prior continuous infusion of a thrombolytic is not an included service and is separately reportable (see 37211 - 37214).

For coronary mechanical thrombectomy, use 92973.

Arterial mechanical thrombectomy may be performed as a ''primary'' transcatheter procedure with pretreatment planning, performance of the procedure, and postprocedure evaluation focused on providing this service. Typically, the diagnosis of thrombus has been made prior to the procedure, and a mechanical thrombectomy is planned preoperatively. Primary mechanical thrombectomy is reported per vascular family using 37184 for the initial vessel treated and 37185 for second or all subsequent vessel(s) within the same vascular family.

Primary mechanical thrombectomy may precede or follow another percutaneous intervention. Most commonly primary mechanical thrombectomy will precede another percutaneous intervention with the decision regarding the need for other services not made until after mechanical thrombectomy has been performed. Occasionally, the performance of primary mechanical thrombectomy may follow another percutaneous intervention.

Do NOT report 37184-37185 for mechanical thrombectomy performed for retrieval of short segments of thrombus or embolus evident during other percutaneous interventional procedures. See 37186 for these procedures.

Arterial mechanical thrombectomy is considered a ''secondary'' transcatheter procedure for removal or retrieval of short segments of thrombus or embolus when performed either before or after another percutaneous intervention (eg, percutaneous transluminal balloon angioplasty, stent placement). Secondary mechanical thrombectomy is reported using 37186. Do NOT report 37186 in conjunction with 37184-37185.

Venous mechanical thrombectomy use 37187 to report the initial application of venous mechanical thrombectomy. To report bilateral venous mechanical thrombectomy performed through a separate access site(s), use modifier -50 in conjunction with 37187. For repeat treatment on a subsequent day during a course of thrombolytic therapy, use 37188.

ARTERIAL MECHANICAL THROMBECTOMY

37184 Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel
(Do not report 37184 in conjunction with 99143-99150)

37185 second and all subsequent vessel(s) within the same vascular family
(List separately in addition to code for primary mechanical thrombectomy procedure)

37186 Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy
(List separately in addition to primary procedure)

VENOUS MECHANICAL THROMBECTOMY

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

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

OTHER PROCEDURES

37191 Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

37192 Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed
(Do not report 37192 in conjunction with 37191)

37193 Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed
(Do not report 37193 in conjunction with 37197)

37195 Thrombolysis, cerebral, by intravenous infusion

37197 Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed

37200 Transcatheter biopsy

37211 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day

37212 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day

37213 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;

37214 cessation of thrombolysis including removal of catheter and vessel closure by any method

(Report 37211 – 37214 once per date of treatment)

37215 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

37216 without distal embolic protection

(37215 and 37216 include all ipsilateral selective carotid catheterization, all diagnostic imaging for ipsilateral, cervical and cerebral carotid arteriography, and all related radiological

supervision and interpretation. When ipsilateral carotid arteriogram (including imaging and selective catheterization) confirms the need for carotid stenting, 37215 and 37216 are inclusive of these services. If carotid stenting is not indicated, then the appropriate codes for carotid catheterization and imaging should be reported in lieu of 37215 and 37216)

37217 Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation

37218 Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation

ILIAC ARTERY REVASCULARIZATION

37220 Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty

37221 with transluminal stent placement(s), includes angioplasty within same vessel, when performed

37222 Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty
(List separately in addition to primary procedure)
(Use 37222 in conjunction with 37220, 37221)

37223 with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
(List separately in addition to primary procedure)
(Use 37223 in conjunction with 37221)

37224 Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty

37225 with atherectomy, includes angioplasty within the same vessel, when performed

37226 with transluminal stent placement(s), includes angioplasty within the same vessel, when performed

37227 with transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel, when performed

37228 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty

37229 with atherectomy, includes angioplasty within the same vessel, when performed

37230 with transluminal stent placement(s), includes angioplasty within the same vessel, when performed

37231 with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

37232 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty
(List separately in addition to primary procedure)
(Use 37232 in conjunction with 37228-37231)

37233 with atherectomy, includes angioplasty within the same vessel, when performed

(List separately in addition to primary procedure)
(Use 37233 in conjunction with 37229-37231)

37234 with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
(List separately in addition to primary procedure)
(Use 37234 in conjunction with 37230, 37231)

37235 with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed
(List separately in addition to primary procedure)
(Use 37235 in conjunction with 37231)

Codes 37246, 37247, 37248, 37249 include radiological supervision and interpretation directly related to the intervention performed and imaging performed to document completion of the intervention.

37246 Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery

37247 each additional artery (List separately in addition to code for primary procedure)

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)

Codes 37236, 37237 describe transluminal intravascular stent insertion into an artery while 37238, 37239 describe transluminal intravascular stent insertion in a vein. Multiple stents placed in a single vessel may only be reported with a single code. If a lesion extends across the margins of one vessel into another, but can be treated with a single therapy, the intervention should be reported only once. When additional, different vessels are treated in the same session, report 37237 and/or 37239 as appropriate. Each code in this family (37236-37239) includes any and all balloon angioplasty(s) performed in the treated vessel, including any pre-dilation (whether performed as a primary of secondary angioplasty), post dilation following stent placement, treatment of a lesion outside the stented segment but in the same vessel, or use of larger/smaller balloon to achieve therapeutic result.

37236 Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery

37237 each additional artery (List separately in addition to code for primary procedure)

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

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

VASCULAR EMBOLIZATION AND OCCLUSION

Codes 37241-37244 are used to describe the work of vascular embolization and occlusion procedures, excluding the central nervous system and the head and neck, which are reported using 61624, 61626, 61710 and 75894, and excluding the ablation/sclerotherapy procedures for venous insufficiency/telangiectasia of the extremities/skin, which are reported using 36468, 36470 and 36471. Embolization and occlusion procedures are performed for a wide variety of clinical indications and in a range of vascular territories. Arteries, veins, and lymphatics may all be the target of embolization.

The embolization codes include all associated radiological supervision and interpretation, intra-procedural guidance and road mapping and imaging necessary to document completion of the procedure.

37241 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles).

37242 arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)

37243 for tumors, organ ischemia, of infarction

37244 for arterial of venous hemorrhage or lymphatic extravasation

INTRAVASCULAR ULTRASOUND SERVICES

Intravascular ultrasound services include all transducer manipulations and repositioning within the specific vessel being examined, both before and after therapeutic intervention (eg, stent placement).

Vascular access for intravascular ultrasound performed during a therapeutic intervention is not reported separately.

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

37253 each additional noncoronary vessel
(List separately in addition to primary procedure)
(Use 37253 in conjunction with 37252)

ENDOSCOPY

Surgical vascular endoscopy always includes diagnostic endoscopy.

37500 Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)

37501 Unlisted vascular endoscopy procedure

LIGATION

(For bilateral procedures for 37650, 37700, 37718, 37722, 37735, 37780, 37785 use modifier -50)

37565 Ligation, internal jugular vein
37600 Ligation; external carotid artery
37605 internal or common carotid artery
37606 internal or common carotid artery, with gradual occlusion, as with Selverstone or Crutchfield clamp
37607 Ligation or banding of angioaccess arteriovenous fistula
37609 Ligation or biopsy, temporal artery
37615 Ligation, major artery (eg, post-traumatic, rupture); neck
37616 chest
37617 abdomen
37618 extremity
37619 Ligation of inferior vena cava
37650 Ligation of femoral vein
37660 Ligation of common iliac vein
37700 Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
(Do not report 37700 in conjunction with 37718, 37722)
37718 Ligation, division and stripping, short saphenous vein
(Do not report 37718 in conjunction with 37735, 37780)
37722 Ligation, division and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
(Do not report 37722 in conjunction with 37700, 37735)
37735 Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia
(Do not report 37735 in conjunction with 37700, 37718, 37722, 37780)
37760 Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open, 1 leg
37761 Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg
(For bilateral procedure, report 37761 with modifier -50)
37765 Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions
37766 more than 20 incisions
37780 Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)
37785 Ligation, division, and/or excision of recurrent or secondary varicose veins (clusters), one leg

OTHER PROCEDURES

37788 Penile revascularization, artery, with or without vein graft
37790 Penile venous occlusive procedure
37799 Unlisted procedure, vascular surgery

HEMIC AND LYMPHATIC SYSTEMS

SPLEEN

EXCISION

38100 Splenectomy; total (separate procedure)
38101 partial
38102 total, en bloc for extensive disease, in conjunction with other procedure (List in addition to primary procedure)

REPAIR

38115 Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

38120 Laparoscopy, surgical, splenectomy
38129 Unlisted laparoscopy procedure, spleen

INTRODUCTION

38200 Injection procedure for splenoportography

GENERAL

BONE MARROW OR STEM CELL SERVICES/PROCEDURES

38220 Diagnostic bone marrow; aspiration(s)
38221 biopsy(ies)
38222 biopsy(ies) and aspiration(s)
38230 Bone marrow harvesting for transplantation; allogeneic
38232 autologous
38240 Hematopoietic progenitor cell (HPC); allogenic transplantation per donor
38241 autologous transplantation
38242 Allogeneic lymphocyte infusions
38243 Hematopoietic progenitor cell (HPC); HPC boost

LYMPH NODES AND LYMPHATIC CHANNELS

INCISION

38300 Drainage of lymph node abscess or lymphadenitis; simple
38305 extensive
38308 Lymphangiotomy or other operations on lymphatic channels

38380 Suture and/or ligation of thoracic duct; cervical approach
38381 thoracic approach
38382 abdominal approach

EXCISION

38500 Biopsy or excision of lymph node(s); open, superficial
(Do not report 38500 with 38700-38780)
38505 by needle, superficial (eg, cervical, inguinal, axillary)
38510 open, deep cervical node(s)
38520 open, deep cervical node(s) with excision scalene fat pad
38525 open, deep axillary node(s)
38530 open, internal mammary node(s) (separate procedure)
(Do not report 38530 with 38720-38746)
38531 open, inguinofemoral node(s)
38542 Dissection, deep jugular node(s)
38550 Excision of cystic hydromel, axillary or cervical; without deep neurovascular dissection
38555 with deep neurovascular dissection

LIMITED LYMPHADENECTOMY FOR STAGING

38562 Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic
38564 retroperitoneal (aortic and/or splenic)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

38570 Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple
38571 with bilateral total pelvic lymphadenectomy
38572 with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy) single or multiple
38573 with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling, peritoneal washings, peritoneal biopsy(ies), omentectomy, and diaphragmatic washings, including diaphragmatic and other serosal biopsy(ies), when performed
38589 Unlisted laparoscopy procedure, lymphatic system

RADICAL LYMPHADENECTOMY (RADICAL RESECTION OF LYMPH NODES)

(For bilateral procedures for 38700, 38720, 38760, 38765, 38770, use modifier -50)

38700 Suprahyoid lymphadenectomy
38720 Cervical lymphadenectomy (complete)
38724 Cervical lymphadenectomy (modified radical neck dissection)
38740 Axillary lymphadenectomy; superficial
38745 complete
38746 Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy

(List separately in addition to primary procedure)
(Report 38746 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32505)

38747 Abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para aortic and vena caval nodes
(List separately in addition to primary procedure)

38760 Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)

38765 Inguinofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)

38770 Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)

38780 Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)

INTRODUCTION

38790 Injection procedure; lymphangiography
(For bilateral procedure, report 38790 with modifier -50)

38792 radioactive tracer for identification of sentinel node

38794 Cannulation, thoracic duct

OTHER PROCEDURES

38900 Intraoperative identification (eg, mapping) of sentinel lymph node(s), includes injection of non-radioactive dye, when performed
(List separately in addition to primary procedure)
(Use 38900 in conjunction with 19302, 19307, 38500, 38510, 38520, 38530, 38542, 38740, 38745)

38999 Unlisted procedure, hemic or lymphatic system

MEDIASTINUM AND DIAPHRAGM

MEDIASTINUM

INCISION

39000 Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; cervical approach

39010 transthoracic approach, including either transthoracic or median sternotomy

EXCISION/RESECTION

39200 Resection of mediastinal cyst

39220 Resection of mediastinal tumor

ENDOSCOPY

39401 Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma),when performed
39402 with lymph node biopsy(ies) (eg, lung cancer staging)

OTHER PROCEDURES

39499 Unlisted procedure, mediastinum

DIAPHRAGM

REPAIR

39501 Repair, laceration of diaphragm, any approach
39503 Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia
(Do not report modifier 63 in conjunction with 39503)
39540 Repair, diaphragmatic hernia (other than neonatal), traumatic; acute
39541 chronic
39545 Imbrication of diaphragm for eventration, transthoracic or transabdominal, paralytic or nonparalytic
39560 Resection, diaphragm, with simple repair (eg, primary suture)
39561 with complex repair (eg, prosthetic material, local muscle flap)

OTHER PROCEDURES

39599 Unlisted procedure, diaphragm

DIGESTIVE SYSTEM

LIPS

EXCISION

40490 Biopsy of lip
40500 Vermilionectomy (lip shave), with mucosal advancement
40510 Excision of lip; transverse wedge excision with primary closure
40520 V-excision with primary direct linear closure
40525 full thickness, reconstruction with local flap (eg, Estlander or fan)
40527 full thickness, reconstruction with cross lip flap (Abbe-Estlander)
40530 Resection lip, more than one-fourth, without reconstruction

REPAIR (CHEILOPLASTY)

40650 Repair lip, full thickness; vermilion only
40652 up to half vertical height
40654 over one-half vertical height, or complex
40700 Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral
40701 primary bilateral, one stage procedure
40702 primary bilateral, one of two stages

40720 secondary, by recreation of defect and reclosure
(For bilateral procedure, use modifier -50)
40761 with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle

OTHER PROCEDURES

40799 Unlisted procedure, lips

VESTIBULE OF MOUTH

The vestibule is the part of the oral cavity outside the dentoalveolar structures, including the mucosal and submucosal tissue of lips and cheeks.

INCISION

40800 Drainage of abscess, cyst, hematoma, vestibule of mouth; simple
40801 complicated
40804 Removal of embedded foreign body; vestibule of mouth; simple
40805 complicated
40806 Incision of labial frenum (frenotomy)

EXCISION, DESTRUCTION

40808 Biopsy, vestibule of mouth
40810 Excision of lesion of mucosa and submucosa vestibule of mouth; without repair
40812 with simple repair
40814 with complex repair
40816 complex with excision of underlying muscle
40818 Excision of mucosa of vestibule of mouth as donor graft
40819 Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)
40820 Destruction of lesion or scar by physical methods (eg, laser, thermal, cryo, chemical)

REPAIR

40830 Closure of laceration, vestibule of mouth; 2.5 cm or less
40831 over 2.5 cm or complex
40840 Vestibuloplasty; anterior
40842 posterior, unilateral
40843 posterior, bilateral
40844 entire arch
40845 complex (including ridge extension, muscle repositioning)

OTHER PROCEDURES

40899 Unlisted procedure, vestibule of mouth

TONGUE AND FLOOR OF MOUTH

INCISION

41000 Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual
41005 sublingual, superficial
41006 sublingual, deep, supramylohyoid
41007 submental space
41008 submandibular space
41009 masticator space
41010 Incision of lingual frenum (frenotomy)
41015 Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual
41016 submental
41017 submandibular
41018 masticator space
41019 Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application

EXCISION

41100 Biopsy of tongue; anterior two-thirds
41105 posterior one-third
41108 Biopsy of floor of mouth
41110 Excision of lesion of tongue without closure
41112 Excision of lesion of tongue with closure; anterior two-thirds
41113 posterior one-third
41114 with local tongue flap
(Do not report 41114 in conjunction with 41112 or 41113)
41115 Excision of lingual frenum (frenectomy)
41116 Excision, lesion of floor of mouth
41120 Glossectomy; less than one-half tongue
41130 hemiglossectomy
41135 partial, with unilateral radical neck dissection
41140 complete or total, with or without tracheostomy, without radical neck dissection
41145 complete or total, with or without tracheostomy, with unilateral radical neck dissection
41150 composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection
41153 composite procedure with resection floor of mouth, with suprahyoid neck dissection
41155 composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)

REPAIR

41250 Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue
41251 posterior one-third of tongue
41252 Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex

OTHER PROCEDURES

41510 Suture of tongue to lip for micrognathia (Douglas type procedure)
41512 Tongue base suspension, permanent suture technique
41520 Frenoplasty (surgical revision of frenum, eg, with Z-plasty)
41530 Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session
41599 Unlisted procedure, tongue, floor of mouth

DENTOALVEOLAR STRUCTURES

INCISION

41800 Drainage of abscess, cyst, hematoma from dentoalveolar structures
41805 Removal of embedded foreign body from dentoalveolar structures; soft tissues
41806 bone

EXCISION, DESTRUCTION

41820 Gingivectomy, excision gingiva, each quadrant
41821 Operculectomy, excision pericoronal tissues
41822 Excision of fibrous tuberosities, dentoalveolar structures
41823 Excision of osseous tuberosities, dentoalveolar structures
41825 Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair
41826 with simple repair
41827 with complex repair
41828 Excision of hyperplastic alveolar mucosa, each quadrant (specify)
41830 Alveolectomy, including curettage of osteitis or sequestrectomy
41850 Destruction of lesion (except excision), dentoalveolar structures

OTHER PROCEDURES

41870 Periodontal mucosal grafting
41872 Gingivoplasty, each quadrant (specify)
41874 Alveoloplasty each quadrant (specify)
41899 Unlisted procedure, dentoalveolar structures

PALATE AND UVULA

INCISION

42000 Drainage of abscess of palate, uvula

EXCISION, DESTRUCTION

42100 Biopsy of palate, uvula
42104 Excision, lesion of palate, uvula; without closure
42106 with simple primary closure
42107 with local flap closure

42120 Resection of palate or extensive resection of lesion
42140 Uvulectomy, excision of uvula
42145 Palatopharyngoplasty eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
42160 Destruction of lesion, palate or uvula (thermal, cryo or chemical)

REPAIR

42180 Repair, laceration of palate; up to 2 cm
42182 over 2 cm or complex
42200 Palatoplasty for cleft palate, soft and/or hard palate only
42205 Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only
42210 with bone graft to alveolar ridge (includes obtaining graft)
42215 Palatoplasty for cleft palate; major revision
42220 secondary lengthening procedure
42225 attachment pharyngeal flap
42226 Lengthening of palate, and pharyngeal flap
42227 Lengthening of palate, with island flap
42235 Repair of anterior palate, including vomer flap
42260 Repair of nasolabial fistula

OTHER PROCEDURES

42299 Unlisted procedure, palate, uvula

SALIVARY GLANDS AND DUCTS

INCISION

42300 Drainage of abscess; parotid, simple
42305 parotid, complicated
42310 submaxillary or sublingual, intraoral
42320 submaxillary, external
42330 Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral
42335 submandibular (submaxillary), complicated, intraoral
42340 parotid, extraoral or complicated intraoral

EXCISION

42400 Biopsy of salivary gland; needle
42405 incisional
42408 Excision of sublingual salivary cyst (ranula)
42409 Marsupialization of sublingual salivary cyst (ranula)
42410 Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection
42415 lateral lobe, with dissection and preservation of facial nerve
42420 total, with dissection and preservation of facial nerve
42425 total, en bloc removal with sacrifice of facial nerve
42426 total, with unilateral radical neck dissection

42440 Excision of submandibular (submaxillary) gland
42450 Excision of sublingual gland

REPAIR

42500 Plastic repair of salivary duct, sialodochoplasty; primary or simple
42505 secondary or complicated
42507 Parotid duct diversion, bilateral (Wilke type procedure);
42509 with excision of both submandibular glands
42510 with ligation of both submandibular (Wharton's) ducts

OTHER PROCEDURES

42550 Injection procedure for sialography
42600 Closure salivary fistula
42650 Dilation salivary duct
42660 Dilation and catheterization of salivary duct, with or without injection
42665 Ligation salivary duct, intraoral
42699 Unlisted procedure, salivary glands or ducts

PHARYNX, ADENOIDS, AND TONSILS

INCISION

42700 Incision and drainage abscess; peritonsillar
42720 retropharyngeal or parapharyngeal, intraoral approach
42725 retropharyngeal or parapharyngeal, external approach

EXCISION, DESTRUCTION

42800 Biopsy; oropharynx
42804 nasopharynx, visible lesion, simple
42806 nasopharynx, survey for unknown primary lesion
42808 Excision or destruction of lesion of pharynx, any method
42809 Removal of foreign body from pharynx
42810 Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues
42815 Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx
42820 Tonsillectomy and adenoidectomy; under age 12
42821 age 12 or over
42825 Tonsillectomy, primary or secondary; under age 12
42826 age 12 or over
42830 Adenoidectomy, primary; under age 12
42831 age 12 or over
42835 Adenoidectomy, secondary; under age 12
42836 age 12 or over

42842 Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure
42844 closure with local flap (eg, tongue, buccal)
42845 closure with other flap
42860 Excision of tonsil tags
42870 Excision or destruction lingual tonsil, any method (separate procedure)
42890 Limited pharyngectomy
42892 Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls
42894 Resection of pharyngeal wall requiring closure with myocutaneous or fasciocutaneous flap or free muscle, skin, or fascial flap with microvascular anastamosis

REPAIR

42900 Suture pharynx for wound or injury
42950 Pharyngoplasty (plastic or reconstructive operation on pharynx)
42953 Pharyngoesophageal repair

OTHER PROCEDURES

42955 Pharyngostomy (fistulization of pharynx, external for feeding)
42960 Control oropharyngeal hemorrhage primary or secondary (eg, post-tonsillectomy); simple
42961 complicated, requiring hospitalization
42962 with secondary surgical intervention
42970 Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cautery
42971 complicated, requiring hospitalization
42972 with secondary surgical intervention
42999 Unlisted procedure, pharynx, adenoids, or tonsils

ESOPHAGUS

INCISION

43020 Esophagotomy, cervical approach, with removal of foreign body
43030 Cricopharyngeal myotomy
43045 Esophagotomy, thoracic approach, with removal of foreign body

EXCISION

43100 Excision of lesion, esophagus, with primary repair; cervical approach
43101 thoracic or abdominal approach
43107 Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)
43108 with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)

43112 Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (ie, McKeown esophagectomy or tri-incisional esophagectomy)
43113 with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43116 Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction
43117 Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)
43118 with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43121 Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty
43122 Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty
43123 with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43124 Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy
43130 Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach
43135 thoracic approach

ENDOSCOPY

43180 Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed
(Do not report 43180 in conjunction with 69990)
43191 Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)
43192 with directed submucosal injection(s), any substance
43193 with biopsy, single or multiple
43194 with removal of foreign body(s)
43195 with balloon dilation (less than 30 mm diameter)
43196 with insertion of guide wire followed by dilation over guide wire
43197 Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43198 with biopsy, single or multiple
43200 Esophagoscopy, flexible; transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43201 with directed submucosal injection(s), any substance
43202 with biopsy, single or multiple
43204 with injection sclerosis of esophageal varices

43205 with band ligation of esophageal varices
43206 with optical endomicroscopy
43215 with removal of foreign body(s)
43216 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
43217 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43211 with endoscopic mucosal resection

43212 with placement of endoscopic stent (includes pre and post-dilation and guide wire passage, when performed)
43220 with transendoscopic balloon dilation (less than 30 mm diameter)
43213 with dilation of esophagus by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)
43214 with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)
43226 with insertion of guide wire followed by passage of dilator(s) over guide wire
43227 with control of bleeding, any method
43229 with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre and post-dilation and guide wire passage, when performed)
43231 with endoscopic ultrasound examination
(Do not report 43231 in conjunction with 76975)
43232 with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)
43235 Esophogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43236 with directed submucosal injection(s), any substance
43237 with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum and adjacent structures
43238 with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)
43239 with biopsy, single or multiple
43240 with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed and endoscopic ultrasound, when performed)
43241 with insertion of intraluminal tube or catheter
43242 with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastamosis)
43243 with injection sclerosis of esophageal gastric varices
43244 with band ligation of esophageal gastric varices
43245 with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)
(Do not report 43245 in conjunction with 43256)
43246 with directed placement of percutaneous gastrostomy tube
43247 with removal of foreign body(s)

43248 with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire
43249 with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)
43233 with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)
43250 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
43251 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43252 with optical endomicroscopy
43253 with transendoscopic ultrasound-guided transmural injection or diagnostic or therapeutic substances(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophogus, stomach and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)
43254 with endoscopic mucosal resection
43255 with control of bleeding, any method
43266 with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
43257 with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophogeal reflux disease
43270 with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
43259 with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis
43210 with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed
43260 Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43261 with biopsy, single or multiple
43262 with sphincterotomy/papillotomy
43263 with pressure measurement of sphincter of Oddi
43264 with removal of calculi/debris from biliary pancreatic duct(s)
43265 with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)
43273 Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)
43274 with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent
43275 with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)
43276 with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged
43277 with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty) including sphincterotomy, when performed, each duct

43278 with ablation of tumor(s), polyp(s), or other lesion(s) including pre- and post-dilation and guide wire passage, when performed

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

43279 Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed
(Do not report 43279 in conjunction with 43280)
43280 Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)
(Do not report 43280 in conjunction with 43279)

43281 Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh
43282 with implantation of mesh
(Do not report 43281, 43282 in conjunction with 43280, 43450, 43453, 43456, 43458, 49568)
43283 Laparoscopy, surgical, esophageal lengthening procedure (eg, Collins gastroplasty or wedge gastroplasty)
(List separately in addition to primary procedure)
(Use 43283 in conjunction with 43280, 43281, 43282)
43286 Esophagectomy, total or near total, with laparoscopic mobilization of the abdominal and mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure, if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, laparoscopic transhiatal esophagectomy)
43287 Esophagectomy, distal two-thirds, with laparoscopic mobilization of the abdominal and lower mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with separate thoracoscopic mobilization of the middle and upper mediastinal esophagus and thoracic esophagogastrostomy (ie, laparoscopic thoracoscopic esophagectomy, Ivor Lewis esophagectomy)
43288 Esophagectomy, total or near total, with thoracoscopic mobilization of the upper, middle and lower mediastinal esophagus, with separate laparoscopic proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or espophagogastrostomy (ie, thorascopic, laparoscopic and cervical incision esophagectomy, McKeown esophagectomy, tri-incisional esophagectomy)
43289 Unlisted laparoscopy procedure, esophagus

REPAIR

43300 Esophagoplasty, (plastic repair or reconstruction), cervical approach; without repair of tracheoesophageal fistula
43305 with repair of tracheoesophageal fistula
43310 Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula
43312 with repair of tracheoesophageal fistula
43313 Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach, without repair of congenital tracheoesophageal fistula

43314 with repair of congenital tracheoesophageal fistula
(Do not report modifier –63 in conjunction with 43313, 43314)
43320 Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach
43325 Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)
43327 Esophagogastric fundoplasty partial or complete; laparotomy
43328 thoracotomy
43330 Esophagomyotomy (Heller type); abdominal approach
43331 thoracic approach
43332 Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis
43333 with implantation of mesh or other prosthesis
43334 Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis
43335 with implantation of mesh or other prosthesis
43336 Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis
43337 with implantation of mesh or other prosthesis
43338 Esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty)
(List separately in addition to primary procedure)
(Use 43338 in conjunction with 43280, 43327-43337)
43340 Esophagojejunostomy (without total gastrectomy); abdominal approach
43341 thoracic approach
43351 Esophagostomy, fistulization of esophagus, external; thoracic approach
43352 cervical approach
43360 Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty
43361 with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43400 Ligation, direct, esophageal varices
43405 Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation
43410 Suture of esophageal wound or injury; cervical approach
43415 transthoracic or transabdominal approach
43420 Closure of esophagostomy or fistula; cervical approach
43425 transthoracic or transabdominal approach

MANIPULATION

43450 Dilation of esophagus; by unguided sound or bougie, single or multiple passes
43453 over guide wire
43460 Esophagogastric tamponade, with balloon (Sengstaken type)

OTHER PROCEDURES

43496 Free jejunum transfer with microvascular anastomosis
43499 Unlisted procedure, esophagus

STOMACH

INCISION

43500 Gastrotomy; with exploration or foreign body removal
43501 with suture repair of bleeding ulcer
43502 with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss)
43510 with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin)
43520 Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)
(Do not report modifier 63 in conjunction with 43520)

EXCISION

43605 Biopsy of stomach, by laparotomy
43610 Excision, local; ulcer or benign tumor of stomach
43611 malignant tumor of stomach
43620 Gastrectomy, total; with esophagoenterostomy
43621 with Roux-en-Y reconstruction
43622 with formation of intestinal pouch, any type
43631 Gastrectomy, partial, distal; with gastroduodenostomy
43632 with gastrojejunostomy
43633 with Roux-en-Y reconstruction
43634 with formation of intestinal pouch
43635 Vagotomy when performed with partial distal gastrectomy
(List separately in addition to code(s) for primary procedure)
(Use 43635 in conjunction with 43631, 43632, 43633, 43634)
43640 Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective
43641 parietal cell (highly selective)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

43644 Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
(Do not report 43644 in conjunction with 43846, 49320)
43645 with gastric bypass and small intestine reconstruction to limit absorption
(Do not report 43645 in conjunction with 49320, 43847)
43647 Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648 revision or removal of gastric neurostimulator electrodes, antrum
43651 Laparoscopy, surgical; transection of vagus nerves, truncal

43652 transection of vagus nerves, selective or highly selective
43653 gastrostomy, without construction of gastric tube (eg, Stamm procedure) (separate procedure)
43659 Unlisted laparoscopy procedure, stomach

INTRODUCTION

43752 Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)
(Do not report 43752 in conjunction with critical care codes 99291-99292, neonatal critical care codes 99295-99296, pediatric critical care codes 99293-99294 or low birth weight intensive care service codes 99298-99299)
43753 Gastric intubation and aspiration(s) therapeutic, necessitating physician’s skill (eg, for gastrointestinal hemorrhage), including lavage if performed
43754 Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)
43755 collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin), includes drug administration
43756 Duodenal intubation and aspiration, diagnostic, includes image guidance; single specimen (eg, bile study for crystals or afferent loop culture)
43757 collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration

43761 Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition
(Do not report 43761 in conjunction with 44500, 49446)
43762 Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract
43763 requiring revision of gastrostomy tract

BARIATRIC SURGERY

Bariatric surgical procedures may involve the stomach, duodenum, jejunum, and/or the ileum.

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

Typical postoperative follow-up care after gastric restriction using the adjustable gastric band technique includes subsequent band adjustment(s) through the postoperative period for the typical patient. Band adjustment refers to changing the gastric band component diameter by injection or aspiration of fluid through the subcutaneous port component.

43770 Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
(For individual component placement, report 43770 with modifier 52)
43771 revision of adjustable gastric restrictive device component only

43772 removal of adjustable gastric restrictive component only
43773 removal and replacement of adjustable gastric restrictive device component only
(Do not report 43773 in conjunction with 43772)
43774 removal of adjustable gastric restrictive device and subcutaneous port components
43775 longitudinal gastrectomy (ie, sleeve gastrectomy)

OTHER PROCEDURES

43800 Pyloroplasty
43810 Gastroduodenostomy
43820 Gastrojejunostomy; without vagotomy
43825 with vagotomy, any type
43830 Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)
43831 neonatal, for feeding
(Do not report modifier 63 in conjunction with 43831)
43832 with construction of gastric tube (eg, Janeway procedure)
43840 Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury
43842 Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843 other than vertical-banded gastroplasty
43845 Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
(Do not report 43845 in conjunction with 43633, 43847, 44130, 49000)
43846 Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847 with small intestine reconstruction to limit absorption
43848 Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43850 Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy
43855 with vagotomy
43860 Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
43865 with vagotomy
43870 Closure of gastrostomy, surgical
43880 Closure of gastrocolic fistula
43881 Implantation or replacement of gastric neurostimulator electrodes, antrum, open
43882 Revision or removal of gastric neurostimulator electrodes, antrum, open
43886 Gastric restrictive procedure, open; revision of subcutaneous port component only
43887 removal of subcutaneous port component only
43888 removal and replacement of subcutaneous port component only
(Do not report 43888 in conjunction with 43774, 43887)
43999 Unlisted procedure, stomach

INTESTINES (EXCEPT RECTUM)

INCISION

44005 Enterolysis (freeing of intestinal adhesion) (separate procedure)
(Do not report 44005 in addition to 45136)
44010 Duodenotomy, for exploration, biopsy(s), or foreign body removal
44015 Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method
(List separately in addition to primary procedure)
44020 Enterotomy, small bowel, other than duodenum; for exploration, biopsy(s), or foreign body removal
44021 for decompression (eg, Baker tube)
44025 Colotomy, for exploration, biopsy(s), or foreign body removal
44050 Reduction of volvulus, intussusception, internal hernia, by laparotomy
44055 Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg, Ladd procedure)
(Do not report modifier 63 in conjunction with 44055)

EXCISION

44100 Biopsy of intestine by capsule, tube, peroral (one or more specimens)
44110 Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy
44111 multiple enterotomies
44120 Enterectomy, resection of small intestine; single resection and anastomosis
(Do not report 44120 in addition to 45136)
44121 each additional resection and anastomosis
(List separately in addition to primary procedure)
(Use 44121 in conjunction with 44120)
44125 with enterostomy
44126 Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine, without tapering
44127 with tapering
44128 each additional resection and anastomosis
(List separately in addition to primary procedure)
(Use 44128 in conjunction with 44126, 44127)
(Do not report modifier 63 in conjunction with 44126, 44127, 44128)
44130 Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)
44133 Donor enterectomy, open, (with preparation and maintenance of allograft); partial, from living donor
44135 Intestinal allotransplantation; from cadaver donor
44136 from living donor
44137 Removal of transplanted intestinal allograft, complete
44139 Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy

(List separately in addition to primary procedure)
(Use 44139 only for codes 44140-44147)

44140 Colectomy, partial; with anastomosis
44141 with skin level cecostomy or colostomy
44143 with end colostomy and closure of distal segment (Hartmann type procedure)
44144 with resection, with colostomy or ileostomy and creation of mucofistula
44145 with coloproctostomy (low pelvic anastomosis)
44146 with coloproctostomy (low pelvic anastomosis), with colostomy
44147 abdominal and transanal approach
44150 Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy
44151 with continent ileostomy
44155 Colectomy, total, abdominal, with proctectomy; with ileostomy
44156 with continent ileostomy
44157 with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed
44158 with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed
44160 Colectomy, partial, with removal of terminal ileum with ileocolostomy

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

INCISION

44180 Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion) (separate procedure)

ENTEROSTOMY-EXTERNAL FISTULIZATION OF INTESTINES

44186 Laparoscopy, surgical; jejunostomy (eg, for decompression or feeding)
44187 ileostomy or jejunostomy, non-tube
44188 Laparoscopy, surgical, colostomy or skin level cecostomy
(Do not report 44188 in conjunction with 44970)

EXCISION

44202 Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis
44203 each additional small intestine resection and anastomosis
(List separately in addition to primary procedure)
(Use 44203 in conjunction with code 44202)
44204 colectomy, partial, with anastomosis
44205 colectomy, partial, with removal of terminal ileum with ileocolostomy
44206 colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)

44207 colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)
44208 colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy
44210 colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy
44211 colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed
44212 colectomy, total, abdominal, with proctectomy, with ileostomy
44213 Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy
(List separately in addition to primary procedure)
(Use 44213 in conjunction with 44204-44208)

REPAIR

44227 Laparoscopy, surgical, closure of enterostomy, large or small intestine, with resection and anastomosis

OTHER PROCEDURES

44238 Unlisted laparoscopy procedure, intestine (except rectum)

ENTEROSTOMY - EXTERNAL FISTULIZATION OF INTESTINES

44300 Placement, enterostomy, or cecostomy, tube open (eg, for feeding or decompression) (separate procedure)
44310 Ileostomy or jejunostomy, non-tube
(For laparoscopic procedure, use 44187)
(Do not report 44310 in conjunction with 44144, 44150-44151, 44155, 44156, 45113, 45119, 45136)
44312 Revision of ileostomy; simple (release of superficial scar) (separate procedure)
44314 complicated (reconstruction in depth) (separate procedure)
44316 Continent ileostomy (Kock procedure) (separate procedure)
44320 Colostomy or skin level cecostomy;
(Do not report 44320 in conjunction with 44141, 44144, 44146, 44605, 45110, 45119, 45126, 45563, 45805, 45825, 50810, 51597, 57307, or 58240)
44322 with multiple biopsies (eg, for congenital megacolon) (separate procedure)
44340 Revision of colostomy; simple (release of superficial scar) (separate procedure)
44345 complicated (reconstruction in depth) (separate procedure)
44346 with repair of paracolostomy hernia (separate procedure)

ENDOSCOPY, SMALL INTESTINE AND STOMAL

Surgical endoscopy always includes diagnostic endoscopy.

44360 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44361 with biopsy, single or multiple
44363 with removal of foreign body(s)
44364 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44365 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
44366 with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44369 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44370 with transendoscopic stent placement (includes predilation)
44372 with placement of percutaneous jejunostomy tube
44373 with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube
44376 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44377 with biopsy, single or multiple
44378 with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44379 with transendoscopic stent placement (includes predilation)
44380 Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44382 with biopsy, single or multiple
44381 with transendoscopic balloon dilation
(Do not report 44381 in conjunction with 44380,44384)
44384 with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
44385 Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44386 with biopsy, single or multiple
44388 Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44389 with biopsy, single or multiple
44390 with removal of foreign body(s)
44391 with control of bleeding, any method
44392 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
44401 with ablation of tumor(s), polyp(s), or other lesions(s), (includes pre- and post-dilation and guide wire passage, when performed)
44394 with removal of tumor(s), polyp(s), or other lesion(s) by snare techniques

44402 with endoscopic stent placement (including pre- and post-dilaton and guide wire passage, when performed)

44403 with endoscopic mucosal resection
44404 with directed submucosal injection(s), any substance
44405 with transendoscopic balloon dilation
44406 with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44407 with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44408 with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed

INTRODUCTION

44500 Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)

REPAIR

44602 Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury, or rupture; single perforation
44603 multiple perforations
44604 Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy
44605 with colostomy
44615 Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction
44620 Closure of enterostomy, large or small intestine;
44625 with resection and anastomosis other than colorectal
44626 with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)
44640 Closure of intestinal cutaneous fistula
44650 Closure of enteroenteric or enterocolic fistula
44660 Closure of enterovesical fistula; without intestinal or bladder resection
44661 with intestine and/or bladder resection
44680 Intestinal plication (separate procedure)

OTHER PROCEDURES

44700 Exclusion of small intestine from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum)
44701 Intraoperative colonic lavage
(List separately in addition to primary procedure)
(Use 44701 in conjunction with 44140, 44145, 44150, or 44604 as appropriate)
(Do not report 44701 in conjunction with 44300, 44950-44960)

44799 Unlisted procedure, small intestine

MECKEL'S DIVERTICULUM AND THE MESENTERY

EXCISION

44800 Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct
44820 Excision of lesion of mesentery (separate procedure)

SUTURE

44850 Suture of mesentery (separate procedure)

OTHER PROCEDURES

44899 Unlisted procedure, Meckel's diverticulum and the mesentery

APPENDIX

INCISION

44900 Incision and drainage of appendiceal abscess; open

EXCISION

44950 Appendectomy;
(Incidental appendectomy during intra-abdominal surgery does not warrant a separate identification)
44955 when done for indicated purpose at time of other major procedure (not as separate procedure)
(List separately in addition to primary procedure)
44960 for ruptured appendix with abscess or generalized peritonitis

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

44970 Laparoscopy, surgical, appendectomy
44979 Unlisted laparoscopy procedure, appendix

RECTUM

INCISION

45000 Transrectal drainage of pelvic abscess
45005 Incision and drainage of submucosal abscess, rectum
45020 Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess
(See also 46050, 46060)

EXCISION

45100 Biopsy of anorectal wall, anal approach (eg, congenital megacolon)
45108 Anorectal myomectomy
45110 Proctectomy; complete, combined abdominoperineal, with colostomy
45111 partial resection of rectum, transabdominal approach
45112 Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis)
45113 Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy
45114 Proctectomy, partial, with anastomosis; abdominal and transsacral approach
45116 transsacral approach only (Kraske type)
45119 Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed
45120 Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull through procedure and anastomosis (eg, Swenson, Duhamel, or Soave type operation)
45121 with subtotal or total colectomy, with multiple biopsies
45123 Proctectomy, partial, without anastomosis, perineal approach
45126 Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof
45130 Excision of rectal procidentia, with anastomosis; perineal approach
45135 abdominal and perineal approach
45136 Excision of ileoanal reservoir with Ileostomy
(Do not report 45136 in addition to 44005, 44120, 44310)
45150 Division of stricture of rectum
45160 Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach
45171 Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)
45172 including muscularis propria (ie, full thickness)
(For destruction of rectal tumor, transanal approach, use 45190)

DESTRUCTION

45190 Destruction of rectal tumor, (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach

ENDOSCOPY

DEFINITIONS:

PROCTOSIGMOIDOSCOPY- is the examination of the rectum and sigmoid colon.

SIGMOIDOSCOPY- is the examination of the entire rectum, sigmoid colon and may include examination of a portion of the descending colon.

COLONOSCOPY- is the examination of the entire colon, from the rectum to the cecum, and may include the examination of the terminal ileum.

(Surgical endoscopy always includes diagnostic endoscopy)

45300 Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45303 with dilation, (eg, balloon, guide wire, bougie)
45305 with biopsy, single or multiple
45307 with removal of foreign body
45308 with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
45309 with removal of single tumor, polyp, or other lesion by snare technique
45315 with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
45317 with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45320 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (eg, laser)
45321 with decompression of volvulus
45327 with transendoscopic stent placement (includes predilation)
45330 Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45331 with biopsy, single or multiple
45332 with removal of foreign body(s)
45333 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45334 with control of bleeding, any method
45335 with directed submucosal injection(s), any substance
45337 with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube when performed
45338 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45346 with ablation of tumor(s), polyp(s), or other lesions(s), (includes pre- and post-dilation and guide wire passage, when performed)
45340 with transendoscopic balloon dilation
45341 with endoscopic ultrasound examination
45342 with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45347 with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
45349 with endoscopic mucosal resection
45350 with band ligation(s) (eg, hemorrhoids)
45378 Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

45379 with removal of foreign body(s)
45380 with biopsy, single or multiple
45381 with directed submucosal injection(s), any substance
45382 with control of bleeding, any method
45388 with ablation of tumor(s), polyp(s), or other lesions(s), (includes pre- and post-dilation and guide wire passage, when performed)
45384 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45385 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386 with transendoscopic balloon dilation
45389 with endoscopic stent placement (including pre- and post-dilaton and guide wire passage, when performed)
45391 with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse or ascending colon and cecum, and adjacent structures
45392 with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45390 with endoscopic mucosal resection
45393 with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
45398 with band ligation(s) (eg, hemorrhoids)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

EXCISION

45395 Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy
45397 proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy, when performed

REPAIR

45400 Laparoscopy, surgical; proctopexy (for prolapse)
45402 proctopexy (for prolapse), with sigmoid resection
45499 Unlisted laparoscopy procedure, rectum

REPAIR

45500 Proctoplasty; for stenosis
45505 for prolapse of mucous membrane
45520 Perirectal injection of sclerosing solution for prolapse
45540 Proctopexy (eg, for prolapse); abdominal approach
45541 perineal approach

45550 with sigmoid resection, abdominal approach
45560 Repair of rectocele (separate procedure)
45562 Exploration, repair, and presacral drainage for rectal injury;
45563 with colostomy
45800 Closure of rectovesical fistula;
45805 with colostomy
45820 Closure of rectourethral fistula;
45825 with colostomy

MANIPULATION

45900 Reduction of procidentia (separate procedure) under anesthesia
45905 Dilation of anal sphincter (separate procedure) under anesthesia other than local
45910 Dilation of rectal stricture (separate procedure) under anesthesia other than local
45915 Removal of fecal impaction or foreign body (separate procedure) under anesthesia

OTHER PROCEDURES

45399 Unlisted procedure, colon
45999 Unlisted procedure, rectum

ANUS

INCISION

46020 Placement of seton
(Do not report 46020 in addition to 46060, 46280, 46600)
46030 Removal of anal seton, other marker
46040 Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)
46045 Incision and drainage of intramural, intramuscular or submucosal abscess, transanal, under anesthesia
46050 Incision and drainage, perianal abscess, superficial
(See also 45020, 46060)
46060 Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton
(Do not report 46060 in addition to 46020)
(See also 45020)
46070 Incision, anal septum (infant)
(Do not report modifier –63 in conjunction with 46070)
46080 Sphincterotomy, anal, division of sphincter (separate procedure)
46083 Incision of thrombosed hemorrhoid, external

EXCISION

46200 Fissurectomy, including sphincterotomy, when performed
46221 Hemorrhoidectomy, internal, by rubber band ligation(s)
46945 Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid

column/group, without imaging guidance
46946 2 or more hemorrhoid columns/group, without imaging guidance
46948 Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups including ultrasound guidance, with mucopexy, when performed
46220 Excision of single external papilla or tag, anus
46230 Excision of multiple external papillae or tags, anus
46320 Excision of thrombosed hemorrhoid, external
46250 Hemorrhoidectomy, external, 2 or more columns/groups
46255 Hemorrhoidectomy, internal and external, simple column/group;
46257 with fissurectomy
46258 with fistulectomy, including fissurectomy, when performed
46260 Hemorrhoidectomy, internal and external, 2 or more columns/groups;
46261 with fissurectomy
46262 with fistulectomy, including fissurectomy, when performed
46270 Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous
46275 intersphincteric
46280 transsphincteric, suprasphincteric, extrasphincteric or multiple, including placement of seton, when performed
(Do not report 46280 in conjunction with 46020)
46285 second stage
46288 Closure of anal fistula with rectal advancement flap

INTRODUCTION

46500 Injection of sclerosing solution, hemorrhoids
46505 Chemodenervation of internal anal sphincter

ENDOSCOPY

(Surgical endoscopy always includes diagnostic endoscopy)

46600 Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
46601 diagnostic, with high resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed
46604 with dilation, (eg, balloon, guide wire, bougie)
46606 with biopsy, single or multiple
46607 with high resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple
46608 with removal of foreign body
46610 with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
46611 with removal of single tumor, polyp, or other lesion by snare technique

46612 with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
46614 with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
46615 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

REPAIR

46700 Anoplasty, plastic operation for stricture; adult
46705 infant
46706 Repair of anal fistula with fibrin glue
46707 Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])
46710 Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach
46712 combined transperineal and transabdominal approach
46715 Repair of low imperforate anus; with anoperineal fistula (cut-back procedure)
46716 with transposition of anoperineal or anovestibular fistula
46730 Repair of high imperforate anus without fistula; perineal or sacroperineal approach
46735 combined transabdominal and sacroperineal approaches
46740 Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach
46742 combined transabdominal and sacroperineal approaches
46744 Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty; sacroperineal approach
46746 Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach
46748 with vaginal lengthening by intestinal graft and pedicle flaps
46750 Sphincteroplasty, anal, for incontinence or prolapse; adult
46751 child
46753 Graft (Thiersch operation) for rectal incontinence and/or prolapse
46754 Removal of Thiersch wire or suture, anal canal
46760 Sphincteroplasty, anal, for incontinence, adult; muscle transplant
46761 levator muscle imbrication (Park posterior anal repair)

DESTRUCTION

46900 Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
46910 electrodesiccation
46916 cryosurgery
46917 laser surgery
46922 surgical excision
46924 Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

46930 Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)
46940 Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); initial
46942 subsequent

SUTURE

46947 Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling

OTHER PROCEDURES

46999 Unlisted procedure, anus

LIVER

INCISION

47000 Biopsy of liver, needle; percutaneous
47001 when done for indicated purpose at time of other major procedure (List separately in addition to primary procedure)
47010 Hepatotomy; for open drainage of abscess or cyst, one or two stages
47015 Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cyst(s) or abscess(es)

EXCISION

47100 Biopsy of liver, wedge
47120 Hepatectomy, resection of liver; partial lobectomy
47122 trisegmentectomy
47125 total left lobectomy
47130 total right lobectomy

LIVER TRANSPLANTATION

47135 Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age

REPAIR

47300 Marsupialization of cyst or abscess of liver
47350 Management of liver hemorrhage; simple suture of liver wound or injury
47360 complex, suture of liver wound or injury, with or without hepatic artery ligation
47361 exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver
47362 re-exploration of hepatic wound for removal of packing

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

47370 Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency
47371 cryosurgical
47379 Unlisted laparoscopic procedure, liver

OTHER PROCEDURES

47380 Ablation, open, of 1 or more liver tumor(s); radiofrequency
47381 cryosurgical
47382 Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency
47383 Ablation, 1 or more liver tumor(s), percutaneous, cryoablation
47399 Unlisted procedure, liver

BILIARY TRACT

INCISION

47400 Hepaticotomy or hepaticostomy with exploration, drainage, or removal of calculus
47420 Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; without transduodenal sphincterotomy or sphincteroplasty
47425 with transduodenal sphincterotomy or sphincteroplasty
47460 Transduodenal sphincterotomy or sphincteroplasty, with or without transduodenal extraction of calculus (separate procedure)
47480 Cholecystotomy or cholecystostomy, open with exploration, drainage, or removal of calculus (separate procedure)

INTRODUCTION

47490 Cholecystotomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation
47531 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access
47532 new access (eg, percutaneous transhepatic cholangiogram)
(Do not report 47531, 47532 in conjunction with 47490, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540, 47541 for procedures performed though the same percutaneous access)
(For intraoperative cholangiography, see 74300, 74301)
47533 Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external
47534 internal-external
47535 Conversion of external biliary drainage catheter to internal-external biliary catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation

47536 Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiologal supervision and interpretation
(Do not report 47536 in conjunction with 47538 for the same access)
(47536 includes exchange of one catheter. For exchange of additional catheter[s]during the same session, report 47536 with modifier 59 for each additional exchange)

47537 Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation

47538 Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation, exisiting access

47539 new access, without placement of separate biliary drainage catheter

47540 new access, with placement of separate biliary drainage catheter (eg, external or internal-external)

47541 Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation, new access

47542 Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, each duct (List separately in addition to code for primary procedure)
(Use 47542 in conjunction with 47531, 47532, 47533, 47534, 47535, 47536, 47537, 47541)
(Do not report 47542 in conjunction with 43262, 43277, 47538, 47539, 47540, 47555, 47556)
(Do not report 47542 in conjunction with 47544 if a balloon is used for removal of calculi, debris, and/or sludge rather than for dilation)
(For percutaneous balloon dilation of multiple ducts during the same session, report an additional dilation once with 47542 and modifier 59, regardless of the number of additional ducts dilated)
(For endoscopic balloon dilation, see 43277, 47555, 47556)

47543 Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple
(List separately in addition to code for primary procedure)
(Use 47543 in conjunction with 47531, 47532, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540)
(Report 47543 once per session)
(For endoscopic brushings, see 43260, 47552)
(For endoscopic biopsy, see 43261, 47553)

47544 Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when

performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

ENDOSCOPY

Surgical endoscopy always includes diagnostic endoscopy.

47550 Biliary endoscopy, intraoperative (choledochoscopy) (List separately in addition to primary procedure)
47552 Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with collection of specimen(s) by brushing and/or washing, when performed (separate procedure)
47553 with biopsy, single or multiple
47554 with removal of calculus/calculi
47555 with dilation of biliary duct stricture(s) without stent
47556 with dilation of biliary duct stricture(s) with stent

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy

47562 Laparoscopy; surgical; cholecystectomy
47563 cholecystectomy with cholangiography
47564 cholecystectomy with exploration of common duct
47570 cholecystoenterostomy
47579 Unlisted laparoscopy procedure, biliary tract

EXCISION

47600 Cholecystectomy;
47605 with cholangiography
47610 Cholecystectomy with exploration of common duct;
47612 with choledochoenterostomy
47620 with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography
47700 Exploration for congenital atresia of bile ducts, without repair, with or without liver biopsy, with or without cholangiography
47701 Portoenterostomy (eg, Kasai procedure) (Do not report modifier 63 in conjunction with 47700, 47701)
47711 Excision of bile duct tumor, with or without primary repair of bile duct; extrahepatic
47712 intraphepatic
47715 Excision of choledochal cyst

REPAIR

47720 Cholecystoenterostomy; direct
47721 with gastroenterostomy
47740 Roux-en-Y

47741 Roux-en-Y with gastroenterostomy
47760 Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract
47765 Anastomosis, of intrahepatic ducts and gastrointestinal tract
47780 Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract
47785 Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal tract
47800 Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis
47801 Placement of choledochal stent
47802 U-tube hepaticoenterostomy
47900 Suture of extrahepatic biliary duct for pre-existing injury (separate procedure)

OTHER PROCEDURES

47999 Unlisted procedure, biliary tract

PANCREAS

INCISION

48000 Placement of drains, peripancreatic, for acute pancreatitis;
48001 with cholecystostomy, gastrostomy, and jejunostomy
48020 Removal of pancreatic calculus

EXCISION

48100 Biopsy of pancreas, open, (eg, fine needle aspiration, needle core biopsy, wedge biopsy)
48102 Biopsy of pancreas, percutaneous needle
48105 Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis
48120 Excision of lesion of pancreas (eg, cyst, adenoma)
48140 Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy
48145 with pancreaticojejunostomy
48146 Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)
48148 Excision of ampulla of Vater
48150 Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, cholecystoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy
48152 without pancreatojejunostomy
48153 Pancreatectomy, proximal subtotal with near-total duodenectomy, cholecystoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy
48154 without pancreatojejunostomy
48155 Pancreatectomy, total
48160 Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells

INTRODUCTION

48400 Injection procedure for intraoperative pancreatography (List separately in addition to primary procedure)

REPAIR

48500 Marsupialization of pancreatic cyst
48510 External drainage, pseudocyst of pancreas; open
48520 Internal anastomosis of pancreatic cyst to gastrointestinal tract; direct
48540 Roux-en-Y
48545 Pancreatorrhaphy for injury
48547 Duodenal exclusion with gastrojejunostomy for pancreatic injury
48548 Pancreaticojejunostomy, side-to-side anastomosis (Puestow-type operation)

PANCREAS TRANSPLANTATION

48554 Transplantation of pancreatic allograft
48556 Removal of transplanted pancreatic allograft

OTHER PROCEDURES

48999 Unlisted procedure, pancreas

ABDOMEN, PERITONEUM, AND OMENTUM

INCISION

49000 Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)
49002 Reopening of recent laparotomy
49010 Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)
49020 Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; open
49040 Drainage of subdiaphragmatic or subphrenic abscess; open
49060 Drainage of retroperitoneal abscess; open
49062 Drainage of extraperitoneal lymphocele to peritoneal cavity, open
49082 Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance
49083 with imaging guidance
49084 Peritoneal lavage, including imaging guidance, when performed (Do not report 49083, 49084 in conjunction with 76942, 77002, 77012, 77021)

EXCISION, DESTRUCTION

49180 Biopsy, abdominal or retroperitoneal mass, percutaneous needle
49185 Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation, when performed

(For treatment of multiple lesions in a single day requiring separate access, use modifier 59 for each additional treated lesion)
(For treatment of multiple interconnected lesions treated through a single access, report 49185 once)

49203 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less

49204 largest tumor 5.1-10.0 cm diameter

49205 largest tumor greater than 10.0 cm diameter

(Do not report 49203-49205 in conjunction with 38770, 38780, 49000, 49010, 49215, 50010, 50205, 50225, 50236, 50250, 50290, 58900-58960)

49215 Excision of presacral or sacrococcygeal tumor
(Do not report modifier 63 in conjunction with 49215)

49250 Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)

49255 Omentectomy, epiploectomy, resection of omentum (separate procedure)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

49320 Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

49321 Laparoscopy, surgical; with biopsy (single or multiple)

49322 with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)

49323 with drainage of lymphocele to peritoneal cavity

49324 with insertion of tunneled intraperitoneal catheter

49325 with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed

49326 with omentopexy (omental tacking procedure)
(List separately in addition to primary procedure)
(Use 49326 in conjunction with 49324, 49325)

49327 with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple
(List separately in addition to primary procedure)
(Use 49327 in conjunction with laparoscopic abdominal, pelvic, or retroperitoneal procedure[s] performed concurrently)

49329 Unlisted laparoscopy procedure, abdomen, peritoneum and omentum

INTRODUCTION, REVISION AND/OR REMOVAL

49400 Injection of air or contrast into peritoneal cavity (separate procedure)

49402 Removal of peritoneal foreign body from peritoneal cavity

49405 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous

49406 peritoneal or retroperitoneal, percutaneous

49407 peritoneal or retroperitoneal, transvaginal or transrectal
49411 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple
49412 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple
(List separately in addition to primary procedure)
(Use 49412 in conjunction with open abdominal, pelvic, or retroperitoneal procedure[s] performed concurrently)
49418 Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous
49419 Insertion of tunneled intraperitoneal catheter, with subcutaneous port (ie, totally implantable)
49421 Insertion of tunneled intraperitoneal catheter for dialysis, open
49422 Removal of tunneled intraperitoneal catheter
49423 Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)
49424 Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure)
49425 Insertion of peritoneal-venous shunt
49426 Revision of peritoneal-venous shunt
49427 Injection procedure (eg, contrast media) for evaluation of previously placed peritoneal-venous shunt
49428 Ligation of peritoneal-venous shunt
49429 Removal of peritoneal-venous shunt
49435 Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site
(List separately in addition to primary procedure)
(Use 49435 in conjunction with 49324, 49421)
49436 Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter

INITIAL PLACEMENT

Do not additionally report 43752 for placement of a nasogastric (NG) or orogastric (OG) tube to insufflate the stomach prior to percutaneous gastrointestinal tube placement. NG or OG tube placement is considered part of the procedure in this family of codes.

49440 Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
(For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, use 49440 in conjunction with 49446)
49441 Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

49442 Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

CONVERSION

49446 Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
(For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, use 49446 in conjunction with 49440)

REPLACEMENT

If an existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube is removed and a new tube is placed via a separate percutaneous access site, the placement of the new tube is not considered a replacement and would be reported using the appropriate initial placement codes 49440-49442.

49450 Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
49451 Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
49452 Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

MECHANICAL REMOVAL OF OBSTRUCTIVE MATERIAL

49460 Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed, image documentation and report
(Do not report 49460 in conjunction with 49450-49452, 49465)

OTHER

49465 Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report
(Do not report 49465 in conjunction with 49450-49460)

REPAIR

HERNIOPLASTY, HERNIORRHAPHY, HERNIOTOMY

The hernia repair codes in this section are categorized primarily by the type of hernia (inguinal, femoral, incisional, etc.). Some types of hernias are further categorized as "initial" or "recurrent" based on whether or not the hernia has required previous repair(s). Additional variables accounted for by some of the codes include patient age and clinical presentation (reducible vs. incarcerated or strangulated).

With the exception of the incisional hernia repairs (see 49560-49566) the use of mesh or other prosthesis is not separately reported.

(Codes 49491-49651 are unilateral procedures. To report bilateral procedures, report modifier -50 with the appropriate procedure code)

(Do not report modifier -63 in conjunction with 49491, 49492, 49495, 49496, 49600, 49605, 49606, 49610, 49611)

49491 Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks post-conception age, with or without hydrocelectomy; reducible
49492 incarcerated or strangulated
49495 Repair initial inguinal hernia, full term infant younger than 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; reducible
49496 incarcerated or strangulated
49500 Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible
49501 incarcerated or strangulated
49505 Repair initial inguinal hernia, age 5 years or over; reducible
49507 incarcerated or strangulated
49520 Repair recurrent inguinal hernia, any age; reducible
49521 incarcerated or strangulated
49525 Repair inguinal hernia, sliding, any age
49540 Repair lumbar hernia
49550 Repair initial femoral hernia, any age; reducible
49553 incarcerated or strangulated
49555 Repair recurrent femoral hernia; reducible
49557 incarcerated or strangulated
49560 Repair initial incisional or ventral hernia; reducible
49561 incarcerated or strangulated
49565 Repair recurrent incisional or ventral hernia; reducible
49566 incarcerated or strangulated
49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection
(List separately in addition to code for the incisional or ventral hernia repair)
(Use 49568 in conjunction with 11004-11006, 49560-49566)
49570 Repair epigastric hernia (eg. preperitoneal fat); reducible (separate procedure);
49572 incarcerated or strangulated
49580 Repair umbilical hernia, younger than age 5 years; reducible
49582 incarcerated or strangulated
49585 Repair umbilical hernia, age 5 years or over; reducible
49587 incarcerated or strangulated
49590 Repair spigelian hernia
49600 Repair of small omphalocele, with primary closure

49605 Repair of large omphalocele or gastroschisis; with or without prosthesis
49606 with removal of prosthesis, final reduction and closure, in operating room
49610 Repair of omphalocele (Gross type operation); first stage
49611 second stage

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

49650 Laparoscopy, surgical; repair initial inguinal hernia
49651 repair recurrent inguinal hernia
49652 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
49653 incarcerated or strangulated
49654 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible
49655 incarcerated or strangulated
49656 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible
49657 incarcerated or strangulated
(Do not report 49652-49657 in conjunction with 44180, 49568)
49659 Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy

SUTURE

49900 Suture, secondary, of abdominal wall for evisceration or dehiscence

OTHER PROCEDURES

49904 Omental flap, extra-abdominal (eg, for reconstruction of sternal and chest wall defects)
(Code 49904 includes harvest and transfer. If a second surgeon harvests the omental flap, then the two surgeons should code 49904 as co-surgeons, using modifier 62)
49905 Omental flap, intra-abdominal
(List separately in addition to primary procedure)
(Do not report 49905 in conjunction with 47700)
49906 Free omental flap with microvascular anastomosis
49999 Unlisted procedure, abdomen, peritoneum and omentum

URINARY SYSTEM

KIDNEY

INCISION

50010 Renal exploration, not necessitating other specific procedures
50020 Drainage of perirenal or renal abscess; open
50040 Nephrostomy, nephrotomy with drainage
50045 Nephrotomy, with exploration

50060 Nephrolithotomy; removal of calculus
50065 secondary surgical operation for calculus
50070 complicated by congenital kidney abnormality
50075 removal of large staghorn calculus filling renal pelvis and calyces (including anatrophic pyelolithotomy)
50080 Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting or basket extraction; up to 2 cm
50081 over 2 cm
50100 Transection or repositioning of aberrant renal vessels (separate procedure)
50120 Pyelotomy; with exploration
50125 with drainage, pyelostomy
50130 with removal of calculus (pyelolithotomy, pelviolithotomy, including coagulum pyelolithotomy)
50135 complicated (eg, secondary operation, congenital kidney abnormality)

EXCISION

50200 Renal biopsy; percutaneous, by trocar or needle
50205 by surgical exposure of kidney
50220 Nephrectomy, including partial ureterectomy, any open approach including rib resection;
50225 complicated because of previous surgery on same kidney
50230 radical, with regional lymphadenectomy and/or vena caval thrombectomy
50234 Nephrectomy with total ureterectomy and bladder cuff; through same incision
50236 through separate incision
50240 Nephrectomy, partial
50250 Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed
50280 Excision or unroofing of cyst(s) of kidney
50290 Excision of perinephric cyst

RENAL TRANSPLANTATION

50320 Donor nephrectomy (including cold preservation); open, from living donor
50340 Recipient nephrectomy (separate procedure)
(For bilateral procedure, report 50340 with modifier 50)
50360 Renal allotransplantation, implantation of graft; without recipient nephrectomy
50365 with recipient nephrectomy
50370 Removal of transplanted renal allograft
50380 Renal autotransplantation, reimplantation of kidney

INTRODUCTION

RENAL PELVIS CATHETER PROCEDURES

INTERNALLY DWELLING

50382 Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation
50384 Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation

50385 Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation
50386 Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation

EXTERNALLY ACCESSIBLE

50387 Removal and replacement of externally accessible transnephric ureteral stent (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation
50389 Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent)

OTHER INTRODUCTION PROCEDURES

50390 Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous
50391 Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent)
50436 Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed;
50437 including new access into the renal collecting system
50396 Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter
50430 Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access
50431 existing access
(Do not report 50430, 50431 in conjunction with 50432, 50433, 50434, 50435, 50693, 50694, 50695, 74425 for the same renal collecting system and/or associated ureter)

50432 Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
50433 Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access
(Do not report 50433 in conjunction with 50430, 50431, 50432, 50693, 50694, 50695, 74425 for the same renal collecting system and/or associated ureter)
50434 Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound

and/or fluoroscopy) and all associated radiological supervision and interpretation, via existing nephrostomy tract
(Do not report 50434 in conjunction with 50430, 50431, 50435, 50684, 50693, 74425 for the same renal collecting system and/or associated ureter)

50435 Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
(Do not report 50435 in conjunction with 50430, 50431, 50434, 50693, 74425 for the same renal collecting system and/or associated ureter)

REPAIR

50400 Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple

50405 complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calycoplasty)

50500 Nephrorrhaphy, suture of kidney wound or injury

50520 Closure of nephrocutaneous or pyelocutaneous fistula

50525 Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; abdominal approach

50526 thoracic approach

50540 Symphysiotomy for horseshoe kidney with or without pyeloplasty and/or other plastic procedure, unilateral or bilateral (one operation)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

50541 Laparoscopy, surgical; ablation of renal cysts

50542 ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed

50543 partial nephrectomy

50544 pyeloplasty

50545 radical nephrectomy (includes removal of Gerota’s fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)

50546 nephrectomy, including partial ureterectomy

50547 donor nephrectomy (including cold preservation), from living donor

50548 nephrectomy with total ureterectomy

50549 Unlisted laparoscopy procedure, renal

ENDOSCOPY

50551 Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;

50553 with ureteral catheterization, with or without dilation of ureter

50555 with biopsy
50557 with fulguration and/or incision, with or without biopsy
50561 with removal of foreign body or calculus
50562 with resection of tumor
50570 Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50572 with ureteral catheterization, with or without dilation of ureter
50574 with biopsy
50575 with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent)
50576 with fulguration and/or incision, with or without biopsy
50580 with removal of foreign body or calculus
(When procedures 50570-50580 provide a significant identifiable service, they may be added to 50045 and 50120)

OTHER PROCEDURES

(Codes 50592, 50593 are unilateral procedures, for bilateral procedures, report with modifier 50)

50590 Lithotripsy, extracorporeal shock wave
50592 Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency
50593 Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy

URETER

INCISION

50600 Ureterotomy with exploration or drainage (separate procedure)
50605 Ureterotomy for insertion of indwelling stent, all types
50606 Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
(Do not report 50606 in conjunction with 50555, 50574, 50955, 50974, 52007, 74425 for the same renal collection system and/or ureter)
50610 Ureterolithotomy; upper one-third of ureter
50620 middle one-third of ureter
50630 lower one-third of ureter

EXCISION

50650 Ureterectomy, with bladder cuff (separate procedure)
50660 Ureterectomy, total, ectopic ureter, combination abdominal, vaginal and/or perineal approach

INTRODUCTION

50684 Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter

50686 Manometric studies through ureterostomy or indwelling ureteral catheter
50688 Change of ureterostomy tube or externally accessible ureteral stent via ileal conduit
50690 Injection procedure for visualization of ileal conduit and/or ureteropyelography, exclusive of radiologic service
50693 Placement or ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract
50694 new access, without separate nephrostomy catheter
50695 new access, with separate nephrostomy catheter
(Do not report 50693, 50694, 50695 in conjunction with 50430, 50431, 50432, 50433, 50434, 50435, 50684, 74425 for the same renal collecting system and/or associated ureter)

REPAIR

50700 Ureteroplasty, plastic operation on ureter (eg, stricture)
50705 Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
50706 Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
(Do not report 50706 in conjunction with 50553, 50572, 50953, 50972, 52341, 52344, 52345, 74485)
50715 Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis
50722 Ureterolysis for ovarian vein syndrome
50725 Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava
50727 Revision of urinary-cutaneous anastomosis (any type urostomy);
50728 with repair of fascial defect and hernia
50740 Ureteropyelostomy, anastomosis of ureter and renal pelvis
50750 Ureterocalycostomy, anastomosis of ureter to renal calyx
50760 Ureteroureterostomy
50770 Transureteroureterostomy, anastomosis of ureter to contralateral ureter
50780 Ureteroneocystostomy; anastomosis of single ureter to bladder
50782 anastomosis of duplicated ureter to bladder
50783 with extensive ureteral tailoring
50785 with vesico-psoas hitch or bladder flap
(Codes 50780-50785 include minor procedures to prevent vesicoureteral reflux)
50800 Ureteroenterostomy, direct anastomosis of ureter to intestine
50810 Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis
50815 Ureterocolon conduit, including intestine anastomosis
50820 Ureteroileal conduit (ileal bladder), including intestine anastomosis (Bricker operation)
50825 Continent diversion, including intestine anastomosis using any segment of small and/or large bowel (Kock pouch or Camey enterocystoplasty)

50830 Urinary undiversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroenterostomy with ureteroureterostomy or ureteroneocystostomy)
50840 Replacement of all or part of ureter by intestine segment, including intestine anastomosis
50845 Cutaneous appendico-vesicostomy
50860 Ureterostomy, transplantation of ureter to skin
50900 Ureterorrhaphy, suture of ureter (separate procedure)
50920 Closure of ureterocutaneous fistula
50930 Closure of ureterovisceral fistula (including visceral repair)
50940 Delegation of ureter

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

50945 Laparoscopy, surgical; ureterolithotomy
50947 ureteroneocystostomy with cystoscopy and ureteral stent placement
50948 ureteroneocystostomy without cystoscopy and ureteral stent placement
50949 Unlisted laparoscopic procedure, ureter

ENDOSCOPY

50951 Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50953 with ureteral catheterization, with or without dilation of ureter
50955 with biopsy
50957 with fulguration and/or incision, with or without biopsy
50961 with removal of foreign body or calculus
50970 Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50972 with ureteral catheterization, with or without dilation of ureter
50974 with biopsy
50976 with fulguration and/or incision, with or without biopsy
50980 with removal of foreign body or calculus
(When procedures 50970-50980 provide a significant identifiable service, they may be added to 50600)

BLADDER

INCISION

51020 Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material
51030 with cryosurgical destruction of intravesical lesion
51040 Cystostomy, cystotomy with drainage
51045 Cystotomy, with insertion of ureteral catheter or stent (separate procedure)
51050 Cystolithotomy, cystotomy with removal of calculus, without vesical neck resection
51060 Transvesical ureterolithotomy
51065 Cystotomy, with calculus basket extraction and/or ultrasonic or electrohydraulic fragmentation of ureteral calculus

51080 Drainage of perivesical or prevesical space abscess

REMOVAL

51100 Aspiration of bladder; by needle
51101 by trocar or intracatheter
51102 with insertion of suprapubic catheter

EXCISION

51500 Excision of urachal cyst or sinus, with or without umbilical hernia repair
51520 Cystotomy; for simple excision of vesical neck (separate procedure)
51525 for excision of bladder diverticulum, single or multiple (separate procedure)
51530 for excision of bladder tumor
51535 Cystotomy for excision, incision, or repair of ureterocele
(For bilateral procedure, use modifier -50)
51550 Cystectomy, partial; simple
51555 complicated (eg, postradiation, previous surgery, difficult location)
51565 Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)
51570 Cystectomy, complete; (separate procedure)
51575 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
51580 Cystectomy, complete with ureterosigmoidostomy or ureterocutaneous transplantations;
51585 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
51590 Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis;
51595 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
51596 Cystectomy, complete, with continent diversion, any technique, using any segment of small and/or large intestine to construct neobladder
51597 Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof

INTRODUCTION

51600 Injection procedure for cystography or voiding urethrocystography
51605 Injection procedure and placement of chain for contrast and/or chain urethrocystography
51610 Injection procedure for retrograde urethrocystography
51700 Bladder irrigation, simple, lavage and/or instillation
51703 Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)
(Code 51703 is reported only when performed independently. Do not report 51703 when catheter insertion is an inclusive component of another procedure)
51710 Change of cystostomy tube; complicated

51715 Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
51720 Bladder instillation of anticarcinogenic agent (including retention time)

URODYNAMICS

The following section (51725-51792) lists procedures that may be used separately or in many and varied combinations.

All procedures in this section imply that these services are performed by, or are under the direct supervision of, a physician and that all instruments, equipment, fluids, gases, probes, catheters, technician's fees, medications, gloves, trays, tubing and other sterile supplies be provided by the physician. When the physician only interprets the results and/or operates the equipment, a professional component, modifier 26, should be used to identify physicians' services.

51725 Simple cystometrogram (CMG) (eg, spinal manometer)
51726 Complex cystometrogram (ie, calibrated electronic equipment);
51727 with urethral pressure profile studies (ie, urethral closure pressure profile), any technique
51728 with voiding pressure studies (ie, bladder voiding pressure), any technique
51729 with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique
51736 Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)
51741 Complex uroflowmetry (eg, calibrated electronic equipment)
51784 Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique
51785 Needle electromyography studies (EMG) of anal or urethral sphincter, any technique
51792 Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)
51797 Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal)
(List separately in addition to primary procedure)
(Use 51797 in conjunction with 51728, 51729)
51798 Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging

REPAIR

51800 Cystoplasty or cystourethroplasty, plastic operation on bladder and/or vesical neck (anterior Y-plasty, vesical fundus resection), any procedure, with or without wedge resection of posterior vesical neck
51820 Cystourethroplasty with unilateral or bilateral ureteroneocystostomy
51840 Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz, Burch); simple
51841 complicated (eg, secondary repair)
51845 Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)
51860 Cystorrhaphy, suture of bladder wound, injury or rupture; simple
51865 complicated

51880 Closure of cystostomy (separate procedure)
51900 Closure of vesicovaginal fistula, abdominal approach
51920 Closure of vesicouterine fistula;
51925 with hysterectomy **(See Rule 14)**
51940 Closure, exstrophy of bladder
(See also 54390)
51960 Enterocystoplasty, including intestinal anastomosis
51980 Cutaneous vesicostomy

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

51990 Laparoscopy, surgical; urethral suspension for stress incontinence
51992 sling operation for stress incontinence (eg, fascia or synthetic)
51999 Unlisted laparoscopy procedure, bladder

ENDOSCOPY - CYSTOSCOPY, URETHROSCOPY, CYSTOURETHROSCOPY

Endoscopic descriptions are listed so that the main procedure can be identified without having to list all the minor related functions performed at the same time. For example: meatotomy, urethral calibration and/or dilation, urethroscopy, and cystoscopy prior to a transurethral resection of prostate; ureteral catheterization following extraction of ureteral calculus; internal urethrotomy and bladder neck fulguration when performing a cystourethroscopy for the female urethral syndrome.

52000 Cystourethroscopy (separate procedure)
52001 Cystourethroscopy with irrigation and evacuation of multiple obstructing clots
(Do not report 52001 in addition to 52000)
52005 Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
52007 with brush biopsy of ureter and/or renal pelvis
52010 Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service

TRANSURETHRAL SURGERY

URETHRA AND BLADDER

52204 Cystourethroscopy, with biopsy(s)
52214 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
52224 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s), with or without biopsy
52234 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)
52235 MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52240 LARGE bladder tumor(s)

52250 Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration
52260 Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
52265 local anesthesia
52270 Cystourethroscopy, with internal urethrotomy; female
52275 male
52276 Cystourethroscopy, with direct vision internal urethrotomy
52277 Cystourethroscopy, with resection of external sphincter (sphincterotomy)
52281 Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
52282 Cystourethroscopy, with insertion of permanent urethral stent
52283 Cystourethroscopy, with steroid injection into stricture
52285 Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone
52287 Cystourethroscopy, with injection(s) for chemodenervation of the bladder
52290 Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral
52300 with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral
52301 with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral
52305 with incision or resection of orifice of bladder diverticulum, single or multiple
52310 Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple
52315 complicated
52317 Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)
52318 complicated or large (over 2.5 cm)

URETER AND PELVIS

Therapeutic cystourethroscopy always includes diagnostic cystourethroscopy. To report a diagnostic cystourethroscopy, use 52000. Therapeutic cystourethroscopy with ureteroscopy and/or pyeloscopy always includes diagnostic cystourethroscopy with ureteroscopy and/or pyeloscopy. To report a diagnostic cystourethroscopy with ureteroscopy and/or pyeloscopy, use 52351.

Do not report 52000 in conjunction with 52320-52343.

Do not report 52351 in conjunction with 52344-52346, 52352-52355.

The insertion and removal of a temporary ureteral catheter (52005) during diagnostic or therapeutic cystourethroscopic with ureteroscopy and/or pyeloscopy is included in 52320-52355 and should not be reported separately.

52320 Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus
52325 with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)
52327 with subureteric injection of implant material

52330 with manipulation, without removal of ureteral calculus
52332 Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double- J type)
52334 Cystourethroscopy, with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde
52341 Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)
52342 with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)
52343 with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)
52344 Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)
52345 with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)
52346 with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)
52351 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic
(Do not report 52351 in conjunction with 52341-52346, 52352-52355)
52352 with removal or manipulation of calculus (ureteral catheterization is included)
52353 with lithotripsy (ureteral catheterization is included)
52354 with biopsy and/or fulguration of ureteral or renal pelvic lesion
52355 with resection of ureteral or renal pelvic tumor
52356 with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

VESICAL NECK AND PROSTATE

52400 Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds
52402 Cystourethroscopy with transurethral resection or incision of ejaculatory ducts
52441 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant
55242 each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)
52450 Transurethral incision of prostate
52500 Transurethral resection of bladder neck (separate procedure)
52601 Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52630 Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52640 of postoperative bladder neck contracture

52647 Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)
52648 Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)
52649 Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)
(Do not report 52649 in conjunction with 52000, 52276, 52281, 52601, 52647, 52648, 53020, 55250)
52700 Transurethral drainage of prostatic abscess

URETHRA

INCISION

53000 Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra
53010 perineal urethra, external
53020 Meatotomy, cutting of meatus (separate procedure); except infant
53025 infant
(Do not report modifier -63 in conjunction with 53025)
53040 Drainage of deep periurethral abscess
53060 Drainage of Skene's gland abscess or cyst
53080 Drainage of perineal urinary extravasation; uncomplicated (separate procedure)
53085 complicated

EXCISION

53200 Biopsy of urethra
53210 Urethrectomy, total, including cystostomy; female
53215 male
53220 Excision or fulguration of carcinoma of urethra
53230 Excision of urethral diverticulum (separate procedure); female
53235 male
53240 Marsupialization of urethral diverticulum, male or female
53250 Excision of bulbourethral gland (Cowper's gland)
53260 Excision or fulguration; urethral polyp(s), distal urethra
53265 urethral caruncle
53270 Skene's glands
53275 urethral prolapse

REPAIR

53400 Urethroplasty; first stage, for fistula, diverticulum, or stricture, (eg, Johannsen type)

53405 second stage (formation of urethra), including urinary diversion
53410 Urethroplasty, one-stage reconstruction of male anterior urethra
53415 Urethroplasty, transpubic or perineal, one stage, for reconstruction or repair of prostatic or membranous urethra
53420 Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425 second stage
53430 Urethroplasty, reconstruction of female urethra
53431 Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg, Tenago, Leadbetter procedure)
53440 Sling operation for correction of male urinary incontinence, (eg, fascia or synthetic)
53442 Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)
53444 Insertion of tandem cuff (dual cuff)
53445 Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
53446 Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53447 Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir and cuff at the same operative session
53448 Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue
(Do not report 11043 in addition to 53448)
53449 Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53450 Urethromeatoplasty, with mucosal advancement
53460 Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
53500 Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring)
(Do not report 53500 in conjunction with 52000)
53502 Urethrorrhaphy, suture of urethral wound or injury; female
53505 penile
53510 perineal
53515 prostatomembranous
53520 Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)

MANIPULATION

53600 Dilation of urethral stricture by passage of sound or urethral dilator, male; initial
53601 subsequent
53605 Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia
53620 Dilation of urethral stricture by passage of filiform and follower, male; initial
53621 subsequent
53660 Dilation of female urethra including suppository and/or instillation; initial
53661 subsequent

53665 Dilation of female urethra, general or conduction (spinal) anesthesia

OTHER PROCEDURES

53850 Transurethral destruction of prostate tissue; by microwave thermotherapy
53852 by radiofrequency thermotherapy
53855 Insertion of a temporary prostatic urethral stent, including urethral measurement
53860 TransTransurethral radiofrequency micro-modeling of the female bladder neck and proximal urethra for stress urinary incontinence
53899 Unlisted procedure, urinary system

MALE GENITAL SYSTEM

PENIS

INCISION

54000 Slitting of prepuce, dorsal or lateral (separate procedure); newborn
(Do not report modifier –63 in conjunction with 54000)
54001 except newborn
54015 Incision and drainage of penis, deep

DESTRUCTION

54050 Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
54055 electrodesiccation
54056 cryosurgery
54057 laser surgery
54060 surgical excision
54065 Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

EXCISION

54100 Biopsy of penis; (separate procedure)
54105 deep structures
54110 Excision of penile plaque (Peyronie disease);
54111 with graft to 5 cm in length
54112 with graft greater than 5 cm in length
54115 Removal foreign body from deep penile tissue (eg, plastic implant)
54120 Amputation of penis; partial
54125 complete
54130 Amputation of penis, radical; with bilateral inguinofemoral lymphadenectomy
54135 in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
54150 Circumcision, using clamp or other device with regional dorsal penile or ring block

(Do not report modifier 63 in conjunction with 54150)

54160 Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less)

(Do not report modifier 63 in conjunction with 54160)

54161 older than 28 days of age

54162 Lysis or excision of penile post-circumcision adhesions

54163 Repair incomplete circumcision

54164 Frenulotomy of penis

(Do not report 54164 with circumcision codes 54150-54161, 54162, 54163)

INTRODUCTION

54200 Injection procedure for Peyronie disease;

54205 with surgical exposure of plaque

54220 Irrigation of corpora cavernosa for priapism

54230 Injection procedure for corpora cavernosography

54240 Penile plethysmography

54250 Nocturnal penile tumescence and/or rigidity test

REPAIR

54300 Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra

54304 Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps

54308 Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm

54312 greater than 3 cm

54316 Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia

54318 Urethroplasty for third stage hypospadias repair to release penis from scrotum (eg, 3rd stage Cecil repair)

54322 One stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V-flap)

54324 with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap)

54326 with urethroplasty by local skin flaps and mobilization of urethra

54328 with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap

54332 One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap

54336 One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap

54340 Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple

54344 requiring mobilization of skin flaps and urethroplasty with flap or patch graft

54348 requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)
54352 Repair of hypospadias cripple requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as flaps or grafts
54360 Plastic operation on penis to correct angulation
54380 Plastic operation on penis for epispadias distal to external sphincter;
54385 with incontinence
54390 with exstrophy of bladder
54400 Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401 inflatable (self-contained)
54405 Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406 Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408 Repair of component(s) of a multi-component, inflatable penile prosthesis
54410 Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411 Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
(Do not report 11043 in addition to 54411)
54415 Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416 Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417 Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
(Do not report 11043 in addition to 54417)
54420 Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral
54430 Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilateral
54435 Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism
54437 Repair of traumatic corporeal tear(s)
54438 Replantation, penis, complete amputation including urethral repair
54440 Plastic operation of penis for injury

MANIPULATION

54450 Foreskin manipulation including lysis of preputial adhesions and stretching

TESTIS

EXCISION

54500 Biopsy of testis, needle (separate procedure)
54505 Biopsy of testis, incisional (separate procedure)
(For bilateral procedure, use modifier -50)
54512 Excision of extraparenchymal lesion of testis
54520 Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
(For bilateral procedure, use modifier -50)
54522 Orchiectomy, partial
54530 Orchiectomy, radical, for tumor; inguinal approach
54535 with abdominal exploration

EXPLORATION

(For 54550, 54560 for bilateral procedure, use modifier -50)

54550 Exploration for undescended testis (inguinal or scrotal area)
54560 Exploration for undescended testis with abdominal exploration

REPAIR

54600 Reduction of torsion of testis, surgical, with or without fixation of contralateral testis
54620 Fixation of contralateral testis (separate procedure)
54640 Orchiopexy, inguinal or scrotal approach
(For bilateral procedure, use modifier 50)
54650 Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)
54660 Insertion of testicular prosthesis (separate procedure)
(For bilateral procedure, use modifier 50)
54670 Suture or repair of testicular injury
54680 Transplantation of testis(es) to thigh (because of scrotal destruction)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

54690 Laparoscopy, surgical; orchiectomy
54692 orchiopexy for intra-abdominal testis
54699 Unlisted laparoscopy procedure, testis

EPIDIDYMIS

INCISION

54700 Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)

EXCISION

54800 Biopsy of epididymis, needle
54830 Excision of local lesion of epididymis

54840 Excision of spermatocele, with or without epididymectomy
54860 Epididymectomy; unilateral
54861 bilateral

EXPLORATION

54865 Exploration of epididymis, with or without biopsy

TUNICA VAGINALIS

INCISION

55000 Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication

EXCISION

55040 Excision of hydrocele; unilateral
55041 bilateral

REPAIR

55060 Repair of tunica vaginalis hydrocele (Bottle type)

SCROTUM

INCISION

55100 Drainage of scrotal wall abscess
(See also 54700)
55110 Scrotal exploration
55120 Removal of foreign body in scrotum

EXCISION

55150 Resection of scrotum

REPAIR

55175 Scrotoplasty; simple
55180 complicated

VAS DEFERENS

INCISION

55200 Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)

EXCISION

55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)

SPERMATIC CORD

EXCISION

55500 Excision of hydrocele of spermatic cord, unilateral (separate procedure)
55520 Excision of lesion of spermatic cord (separate procedure)
55530 Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)
55535 abdominal approach
55540 with hernia repair

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

55550 Laparoscopy, surgical, with ligation of spermatic veins for varicocele
55559 Unlisted laparoscopy procedure, spermatic cord

SEMINAL VESICLES

INCISION

55600 Vesiculotomy;
(For bilateral procedure, use modifier 50)
55605 complicated

EXCISION

55650 Vesiculectomy, any approach
(For bilateral procedure, use modifier 50)
55680 Excision of Mullerian duct cyst

PROSTATE

INCISION

55700 Biopsy, prostate; needle or punch, single or multiple, any approach
55705 incisional, any approach
55720 Prostatotomy, external drainage of prostatic abscess, any approach; simple
55725 complicated

EXCISION

55801 Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)

55810 Prostatectomy, perineal radical;
55812 with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55815 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
(If 55815 is carried out on separate days, use 38770 and 55810)
55821 Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, one or two stages
55831 retropubic, subtotal
55840 Prostatectomy, retropubic radical, with or without nerve sparing;
55842 with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55845 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
(If 55845 is carried out on separate days, use 38770 and 55840)
55860 Exposure of prostate, any approach, for insertion of radioactive substance;
55862 with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55865 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

55866 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed

OTHER PROCEDURES

55873 Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)
55875 Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
55876 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostrate (via needle, any approach, single or multiple
55880 Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance
55899 Unlisted procedure, male genital system
A4648 Tissue marker, implantable, any type, each

REPRODUCTIVE SYSTEM PROCEDURES

55920 Placement of needles or catheters into pelvic organs and/ or genitalia (except prostate) for subsequent interstitial radioelement application

INTERSEX SURGERY
GENDER REASSIGNMENT SURGERY
GENDER REASSIGNMENT SURGERY

Gender reassignment surgery is covered for individuals diagnosed with gender dysphoria who are 18 years of age or older and who have obtained at least two referral letters that, when reviewed in combination, meet the criteria outlined below. For individuals under age 18, coverage is available in specific cases if medical necessity is demonstrated and prior approval is received.

Referral Letters

One letter must be written by a New York State (NYS) licensed psychiatrist, psychologist, psychiatric nurse practitioner or licensed clinical social worker who has an ongoing relationship with the member. The second letter may be written by a NYS licensed psychiatrist, psychologist, physician, psychiatric nurse practitioner or licensed clinical social worker, acting within their scope of practice who has only had an evaluative role with the member. Each referral letter must be signed by the NYS licensed health professional attesting they have independently assessed the member. These referring health professionals may practice at the same organization. The combination of information in these referral letters must indicate that the member has:

- a persistent and well-documented case of gender dysphoria, and
- received hormone therapy appropriate to the member's gender goals, which shall be for a minimum of 12 months in the case of a member seeking genital surgery, unless such therapy is medically contraindicated or the member is otherwise unable to take hormones, and
- lived for 12 months in a gender role congruent with the member's gender identity, and
- received mental health counseling, as deemed medically necessary by the member's treating NYS licensed health professional, and
- no other significant medical or mental health conditions that would be a contraindication to the surgery, or if so, that those are reasonably well-controlled prior to the surgery, and
- the capacity to make a fully informed decision and to consent to the treatment.

Claim Submission Instructions

Gender Reassignment Procedures Requiring by Report Claim Submission

When performing genital surgery for the purposes of gender reassignment, physicians may bill code 55970 (intersex surgery; male to female) or 55980 (intersex surgery; female to male) or any of the codes listed in the sections to follow. When using codes 55970 or 55980, claims must be submitted via paper claim. The physician must include with the paper claim the operation report and copies of the two referral letters from the NYS licensed health practitioners. Practitioners must submit charges on an invoice for review and payment. These procedures do not require prior approval.

55970- Intersex surgery; male to female
The provider performs many staged procedures to convert male anatomy to female anatomy. The procedures include removing the penis, reshaping genital tissue to appear more female and constructing a vagina.

When the patient is appropriately prepped and anesthetized, the provider dissects and removes the penis leaving vital structures intact. Next, the provider incises the scrotum, removes the testes, and pulls back the flap of skin. The provider dissects and opens the region between the scrotum and the anus. The provider then uses the patient's excess skin to line the opening and create a vagina. The provider uses skin from the scrotum and surrounding area to fashion the labia. The provider shortens the urethra and moves the urethral opening to mimic that of a female. The provider then places a stent or obturator into the constructed vagina. Hair removal, if clinically indicated, is included in payment for this procedure.

55980- Intersex surgery; female to male
The provider performs many staged procedures to convert female anatomy to male anatomy. The procedures can include removing the uterus and ovaries and reshaping genital tissue to appear more male and/or constructing a penis.

When the patient is appropriately prepped and anesthetized, the provider removes the uterus and ovaries. The provider then creates a penis by using the clitoris that hormones have previously enlarged; or they construct a penis by using free tissue grafts from the arm, thigh, or belly, along with an erectile prosthetic. For the constructed penis, the provider then reroutes the urethra through the fabricated penis to allow for urination. The provider uses the adjacent skin to form the scrotum, and they insert prosthetic testicles into the constructed pouch. The provider then closes, or removes, the vagina. Hair removal, if clinically indicated, is included in payment for this procedure.

Gender Reassignment Procedures Not Requiring by Report Claim Submission

When performing the following procedures for the purpose of gender reassignment, physicians must obtain and maintain in their records copies of the two referrals letters from the NYS licensed health practitioners. These procedures do not require prior approval or paper claim submission:

19303: Mastectomy, simple, complete
19318: Reduction mammaplasty (unilateral)
19325: Breast augmentation with implant
For male-to-female gender reassignment, augmentation mammaplasty may be considered medically necessary for individuals with a diagnosis of gender dysphoria when:
- that individual's breast growth has been determined to be negligible by the individual's treating NYS licensed health professional after 24 months of cross-sex hormone therapy, or
- hormone therapy is medically contraindicated, or
- the individual is otherwise unable to take hormones.

53410: Urethroplasty, 1-stage reconstruction of male anterior urethra.
53420: Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra.
53430: Urethroplasty, reconstruction of female urethra
54120: Amputation of penis: partial
54125: Amputation of penis; complete

54520: Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54522: Orchiectomy, partial
54660: Insertion of testicular prosthesis (separate procedure)
55175: Scrotoplasty; simple.
55180: Scrotoplasty; complicated
55899: Metoidioplasty/ Phalloplasty (unlisted procedure, male genital system)
56800: Plastic repair of introitus
56805: Clitoroplasty for intersex state
57106: Vaginectomy, partial removal of vaginal wall
57110: Vaginectomy, complete removal of vaginal wall

• Additional instructions for billing the hysterectomy codes listed below can be found in the "General Information and Rules" section at the beginning of this manual, including information on the "Hysterectomy Receipt of Information Form."

58150: Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58152: with colpo-urethrocystopexy (e.g., Marshall-Machetti-Krantz, Burch)
58180: Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260: Vaginal hysterectomy, for uterus 250 grams or less;
58262: with removal of tube(s), and/or ovary(s)
58263: with removal of tube(s), and/or ovary(s), with repair of enterocele
58267: with colpo-urethrocystopexy (Marshall-Marchetti-Krantz Type, Pereyra type, with or without endoscopic control)
58270: with repair of enterocele
58275: Vaginal hysterectomy, with total or partial vaginectomy;
58280: with repair of enterocele
58285: Vaginal hysterectomy, radical (Schauta type operation)
58290: Vaginal hysterectomy, for uterus greater than 250 grams;
58291: with removal of tube(s) and/or ovary(s)
58292: with removal of tube(s) and/or ovary(s), with repair of enterocele
58293: with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58294: with repair of enterocele
58720: Salpingo-oophorectomy, complete or partial, unilateral or bilateral
58940: Oophorectomy, partial or total, unilateral or bilateral

Gender Reassignment Procedures Requiring Prior Approval:

When performing the following procedures for purposes of gender reassignment, prior approval is required. As part of the prior approval request, physicians must, at a minimum, submit copies of the two referral letters from the NYS licensed health practitioners recommending the patient for surgery and additional justification of medical necessity for the requested procedure. Additional information about the prior approval process, including instructions for providers, is available in the Physician Prior Approval Guidelines manual, available at:
https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician_PA_Guidelines.pdf.

11950: Subcutaneous injection of filling material (eg, collagen); 1 cc or less

11951: 1.1 to 5 cc
11952: 5.1 to 10 cc
11954: over 10 cc
15769: Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascial)
15771: Grafting of autologous fat, harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772: each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773: Grafting of autologous fat, harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774: each additional 25 cc or less injectate, or part thereof (List separately in addition to the code for primary procedure)
15775: Punch graft for hair transplant; 1 to 15 punch grafts
15776: more than 15 punch grafts
15820: Blepharoplasty, lower eyelid;
15821: with extensive herniated fat pad
15822: Blepharoplasty, upper eyelid;
15823: with excessive skin weighting down lid
15824: Rhytidectomy; forehead
15825: neck with platysmal tightening (platysmal flap, P-flap)
15826: glabellar frown lines
15828: cheek, chin, and neck
15830: Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832: thigh
15833: leg
15834: hip
15835: buttock
15836: arm
15837: forearm or hand
15838: submental fat pad
15839: other area
15847: Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
15876: Suction assisted lipectomy; head and neck
15877: trunk
15878: upper extremity
15879: lower extremity
17380: Electrolysis epilation, each 30 minutes
19316: Mastopexy (unilateral)
21120: Genioplasty; augmentation (autograft, allograft, prosthetic material)
21123: sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21193: Reconstruction of mandibular rami, horizontal, vertical, "C", or "L" osteotomy; without bone graft
21208: Osteoplasty, facial bones; augmentation (autograft, allograft or prosthetic implant)

21209: reduction

21270: Malar augmentation, prosthetic material

30400: Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip

30410: complete, external parts including bony pyramid, lateral and alar cartilages, and/or

elevation of nasal tip

30420: including major septal repair

30430: Rhinoplasty, secondary; minor revision (small amount of nasal tip work)

30435: intermediate revision (bony work with osteotomies)

30450: major revision (nasal tip work and osteotomies)

30462: tip, septum, osteotomies

30465: Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall

reconstruction)

31599: Unlisted procedure, larynx

40500: Vermilionectomy (lip shave), with mucosal advancement

54400: Insertion of penile prosthesis; non-inflatable (semi-rigid)

54401: Insertion of penile prosthesis; inflatable (self-contained)

54405: Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir

54408: Repair of component(s) of a multi-component, inflatable penile prosthesis

54410: Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session

54411: Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue (Do not report 11043 in addition to 54411)

54416: Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session

54417: Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue (Do not report 11043 in addition to 54417)

67900: Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

When performing the following procedures for purposes of gender reassignment, prior approval is required. As part of the prior approval request, physicians must, at a minimum, submit copies of the two letters from New York State licensed health practitioners recommending the patient for surgery (see June 2015 Medicaid Update), and additional justification of medical necessity for the requested procedure. Information about the prior approval process, including instructions for providers, is available in the Physician Prior Approval Guidelines manual, available at: https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician_PA_Guidelines.pdf.
11950: Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951: 1.1 to 5 cc

11952: 5.1 to 10 cc
11954: over 10 cc
15775: Punch graft for hair transplant; 1 to 15 punch grafts
15776: more than 15 punch grafts
15820: Blepharoplasty, lower eyelid;
15821: with extensive herniated fat pad
15822: Blepharoplasty, upper eyelid;
15823: with excessive skin weighting down lid
15824: Rhytidectomy; forehead
15825: neck with platysmal tightening (platysmal flap, P-flap)
15826: glabellar frown lines
15828: cheek, chin, and neck
15830: Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832: thigh
15833: leg
15834: hip
15835: buttock
15836: arm
15837: forearm or hand
15838: submental fat pad
15839: other area
15847: Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
15876: Suction assisted lipectomy; head and neck
15877: trunk
15878: upper extremity
15879: lower extremity
17380: Electrolysis epilation, each 30 minutes
19316: Mastopexy (unilateral)
21120: Genioplasty; augmentation (autograft, allograft, prosthetic material)
21123: sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21193: Reconstruction of mandibular rami, horizontal, vertical, "C", or "L" osteotomy; without bone graft
21208: Osteoplasty, facial bones; augmentation (autograft, allograft or prosthetic implant)
21209: reduction
21270: Malar augmentation, prosthetic material
30400: Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410: complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420: including major septal repair

30430: Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435: intermediate revision (bony work with osteotomies)
30450: major revision (nasal tip work and osteotomies)

30462: tip, septum, osteotomies
30465: Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
31599: Unlisted procedure, larynx
40500: Vermilionectomy (lip shave), with mucosal advancement
67900: Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

FEMALE GENITAL SYSTEM

VULVA, PERINEUM AND INTROITUS

The following definitions apply to the vulvectomy codes (56620-56640):
Simple: The removal of skin and superficial subcutaneous tissue.
Radical: The removal of skin and deep subcutaneous tissue.
Partial: Removal of less than 80% of the vulvar area.
Complete: The removal of greater than 80% of the vulvar area.

INCISION

56405 Incision and drainage of vulva or perineal abscess
56420 Incision and drainage of Bartholin's gland abscess
56440 Marsupialization of Bartholin's gland cyst
56441 Lysis of labial adhesions
56442 Hymenotomy, simple incision

DESTRUCTION

56501 Destruction of lesion(s), vulva; simple, (laser surgery, electrosurgery, cryosurgery, chemosurgery)
56515 extensive, (laser surgery, electrosurgery, cryosurgery, chemosurgery)

EXCISION

56605 Biopsy of vulva or perineum. (separate procedure); one lesion
56606 each separate additional lesion
(List separately in addition to primary procedure)
(Use 56606 in conjunction with 56605)
56620 Vulvectomy simple; partial
56625 complete
56630 Vulvectomy, radical, partial;
56631 with unilateral inguinofemoral lymphadenectomy
56632 with bilateral inguinofemoral lymphadenectomy
56633 Vulvectomy, radical, complete;
56634 with unilateral inguinofemoral lymphadenectomy
56637 with bilateral inguinofemoral lymphadenectomy
56640 Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy

(For bilateral procedure, use modifier 50)
56700 Partial hymenectomy or revision of hymenal ring
56740 Excision of Bartholin's gland or cyst

REPAIR

56800 Plastic repair of introitus
56805 Clitoroplasty for intersex state
56810 Perineoplasty, repair of perineum, nonobstetrical (separate procedure) (See also 56800)

ENDOSCOPY

56820 Colposcopy of the vulva;
56821 with biopsy(s)

VAGINA

INCISION

57000 Colpotomy; with exploration
57010 with drainage of pelvic abscess
57020 Colpocentesis (separate procedure)
57022 Incision and drainage of vaginal hematoma; obstetrical/post-partum
57023 non-obstetrical (eg, post-trauma, spontaneous bleeding)

DESTRUCTION

57061 Destruction of vaginal lesion(s); simple, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
57065 extensive, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

EXCISION

57100 Biopsy of vaginal mucosa; simple (separate procedure)
57105 extensive, requiring suture (including cysts)
57106 Vaginectomy, partial removal of vaginal wall;
57107 with removal of paravaginal tissue (radical vaginectomy)
57109 with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)
57110 Vaginectomy, complete removal of vaginal wall;
57111 with removal of paravaginal tissue (radical vaginectomy)
57120 Colpocleisis (Le Fort Type)
57130 Excision of vaginal septum
57135 Excision of vaginal cyst or tumor

INTRODUCTION

57150 Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease
57155 Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy
57156 Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy
57160 Fitting and insertion of pessary or other intravaginal support device
57180 Introduction of any hemostatic agent or pack for spontaneous or traumatic nonobstetrical hemorrhage (separate procedure)

REPAIR

57200 Colporrhaphy, suture of injury of vagina (nonobstetrical)
57210 Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical)
57220 Plastic operation on urethral sphincter, vaginal approach (eg, Kelly urethral plication)
57230 Plastic repair of urethrocele
57240 Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed
57250 Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy
57260 Combined anteroposterior colporrhaphy; including cystourethroscopy, when performed;
57265 with enterocele repair
57267 Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach
(List separately in addition to primary procedure)
57268 Repair of enterocele, vaginal approach (separate procedure)
57270 Repair of enterocele, abdominal approach (separate procedure)
57280 Colpopexy, abdominal approach
57282 Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)
57283 intra-peritoneal approach (uterosacral, levator myorrhaphy)
57284 Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach
(Do not report 57284 in conjunction with 51840, 51841, 51990, 57240, 57260, 57265, 58152, 58267)
57285 vaginal approach
(Do not report 57285 in conjunction with 51990, 57240, 57260, 57265, 58267)
57287 Removal or revision of sling for stress incontinence (eg, fascia or synthetic)
57288 Sling operation for stress incontinence (eg, fascia or synthetic)
57289 Pereyra procedure, including anterior colporrhaphy
57291 Construction of artificial vagina; without graft
57292 with graft
57295 Revision (including removal) of prosthetic vaginal graft, vaginal approach
57296 open abdominal approach
57300 Closure of rectovaginal fistula; vaginal or transanal approach
57305 abdominal approach
57307 abdominal approach, with concomitant colostomy
57308 transperineal approach, with perineal body reconstruction, with or without levator plication

57310 Closure of urethrovaginal fistula;
57311 with bulbocavernosus transplant
57320 Closure of vesicovaginal fistula; vaginal approach
57330 transvesical and vaginal approach
57335 Vaginoplasty for intersex state

MANIPULATION

57400 Dilation of vagina under anesthesia (other than local)
57410 Pelvic examination under anesthesia (other than local)
57415 Removal of impacted vaginal foreign body (separate procedure) under anesthesia (other than local)
(For removal without anesthesia of an impacted vaginal foreign body, use the appropriate Evaluation and Management code)

ENDOSCOPY

57420 Colposcopy of the entire vagina, with cervix if present;
57421 with biopsy(s) of vagina/cervix
57423 Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach
(Do not report 57423 in conjunction with 49320, 51840, 51841, 51990, 57240, 57260, 58152, 58267)
57425 Laparoscopy, surgical, colpopexy (suspension of vaginal apex)
57426 Revision (including removal) of prosthetic vaginal graft, laparoscopic approach

CERVIX UTERI

ENDOSCOPY

57452 Colposcopy of the cervix including upper/adjacent vagina;
(Do not report 57452 in addition to 57454-57461)
57454 with biopsy(s) of the cervix and endocervical curettage
57455 with biopsy(s) of the cervix
57456 with endocervical curettage
57460 with loop electrode biopsy(s) of the cervix
57461 with loop electrode conization of the cervix
(Do not report 57456 in addition to 57461)
57465 Computer-aided mapping of cervix uteri during colposcopy, including optical dynamic spectral imaging and algorithmic quantification of the acetowhitening effect (List separately in addition to code for primary procedure)

EXCISION

57500 Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
57505 Endocervical curettage (not done as part of a dilation and curettage)
57510 Cautery of cervix; electro or thermal

57511 cryocautery, initial or repeat
57513 laser ablation
57520 Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser
(See also 58120)
57522 loop electrode excision
57530 Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
57531 Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling biopsy, with or without removal of tube(s), with or without removal of ovary(s)
57540 Excision of cervical stump, abdominal approach;
57545 with pelvic floor repair
57550 Excision of cervical stump, vaginal approach;
57555 with anterior and/or posterior repair
57556 with repair of enterocele
57558 Dilation and curettage of cervical stump

REPAIR

57700 Cerclage of uterine cervix, nonobstetrical
57720 Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach

MANIPULATION

57800 Dilation of cervical canal, instrumental (separate procedure)

CORPUS UTERI

EXCISION

58100 Endometrial sampling (biopsy), with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
58110 Endometrial sampling (biopsy) performed in conjunction with colposcopy
(List separately in addition to primary procedure)
(Use 58110 in conjunction with 57420, 57421, 57452-57461)
58120 Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
58140 Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 grams or less and/or removal of surface myomas; abdominal approach
58145 vaginal approach
58146 Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach
(Do not report 58146 in addition to 58140-58145, 58150-58240)

HYSTERECTOMY PROCEDURES

(For codes 58150-58294, See Rule 14, Receipt of Hysterectomy Information)

58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58152 with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)
58180 Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58200 Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)
58210 Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)
58240 Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
58260 Vaginal hysterectomy, for uterus 250 grams or less;
58262 with removal of tube(s), and/or ovary(s)
58263 with removal of tube(s), and/or ovary(s), with repair of enterocele
(Do not report 58263 in addition to 57283)
58267 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz Type, Pereyra type, with or without endoscopic control)
58270 with repair of enterocele
58275 Vaginal hysterectomy, with total or partial vaginectomy;
58280 with repair of enterocele
58285 Vaginal hysterectomy, radical (Schauta type operation)
58290 Vaginal hysterectomy, for uterus greater than 250 grams;
58291 with removal of tube(s) and/or ovary(s)
58292 with removal of tube(s) and/or ovary(s), with repair of enterocele
58294 with repair of enterocele

INTRODUCTION

58300 Insertion of intrauterine device (IUD)
58301 Removal of intrauterine device (IUD)
58340 Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (sis) or hysterosalpingography
58346 Insertion of Heyman capsules for clinical brachytherapy
58353 Endometrial ablation, thermal, without hysteroscopic guidance
58356 Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed

REPAIR

58400 Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)
58410 with presacral sympathectomy

58520 Hysterorrhaphy, repair of ruptured uterus (nonobstetrical)
58540 Hysteroplasty, repair of uterine anomaly (Strassman type)

LAPAROSCOPY / HYSTEROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

(For codes 58541-58544, 58548-58554, 58570-58573, See Rule 14, Receipt of Hysterectomy Information)

(For code 58565, See Rule 13, Informed Consent for Sterilization)

58541 Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542 with removal of tube(s) and/or ovary(s)
58543 Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544 with removal of tube(s) and/or ovary(s)
58545 Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas
58546 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams
58548 Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed
(Do not report 58548 in conjunction with 38570-38572, 58210, 58285, 58550-58554)
58550 Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less;
58552 with removal of tube(s) and/or ovary(s)
58553 Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;
58554 with removal of tube(s) and/or ovary(s)
58555 Hysteroscopy, diagnostic (separate procedure)
58558 Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D&C
58559 with lysis of intrauterine adhesions (any method)
58560 with division or resection of intrauterine septum (any method)
58561 with removal of leiomyomata
58562 with removal of impacted foreign body
58563 with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)
58565 with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
(Do not report 58565 in conjunction with 58555 or 57800)
A4264 Permanent implantable contraceptive intratubal occlusion device(s) and delivery system
58570 Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571 with removal of tube(s) and/or ovary(s)
58572 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
58573 with removal of tube(s) and/or ovary(s)
58575 Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed

58578 Unlisted laparoscopy procedure, uterus
58579 Unlisted hysteroscopy procedure, uterus

OVIDUCT/OVARY

INCISION

(For codes 58600-58615, See Rule 13, Informed Consent for Sterilization)

58600 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)
58611 Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure)
(List separately in addition to primary procedure)
58615 Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

(For codes 58670, 58671, See Rule 13, Informed Consent for Sterilization)

58660 Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
58661 with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58662 with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method
58670 with fulguration of oviducts (with or without transection)
58671 with occlusion of oviducts by device (eg, band, clip, or Falope ring)
58673 with salpingostomy (salpingoneostomy)
(Code 58673 is used to report unilateral procedures, for bilateral procedure, use modifier -50)
58679 Unlisted laparoscopy procedure, oviduct, ovary

EXCISION

58700 Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720 Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

REPAIR

58740 Lysis of adhesions (salpingolysis, ovariolysis)
58770 Salpingostomy (salpingoneostomy)

OVARY

INCISION

58800 Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); vaginal approach
58805 abdominal approach
58820 Drainage of ovarian abscess; vaginal approach, open
58822 abdominal approach
58825 Transposition, ovary(s)

EXCISION

(For codes 58951, 58953, 58954, 58956, See Rule 14, Receipt of Hysterectomy Information)

58900 Biopsy of ovary, unilateral or bilateral (separate procedure)
58920 Wedge resection or bisection of ovary, unilateral or bilateral
58925 Ovarian cystectomy, unilateral or bilateral
58940 Oophorectomy, partial or total, unilateral or bilateral;
58943 for ovarian, tubal or primary peritoneal malignancy, with para aortic and pelvic lymph node biopsies, peritoneal washings, peritoneal biopsies, diaphragmatic assessments, with or without salpingectomy(s) with or without omentectomy
58950 Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy;
58951 with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy
58952 with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)
58953 Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;
58954 with pelvic lymphadenectomy and limited para-aortic lymphadenectomy
58956 Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy
(Do not report 58956 in conjunction with 49255, 58150, 58180, 58262, 58263, 58550, 58661, 58700, 58720, 58900, 58925, 58940, 58957, 58958)
58957 Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;
58958 with pelvic lymphadenectomy and limited para-aortic lymphadenectomy
(Do not report 58957, 58958 in conjunction with 38770, 38780, 44005, 49000, 49203-49215, 49255, 58900-58960)
58960 Laparotomy, for staging or restaging of ovarian, tubal or primary peritoneal malignancy (second look), with or without omentectomy, peritoneal washing, biopsy of abdominal and pelvic peritoneum, diaphragmatic assessment with pelvic and limited para-aortic lymphadenectomy
(Do not report 58960 in conjunction with 58957, 58958)
58999 Unlisted procedure, female genital system, nonobstetrical

MATERNITY CARE AND DELIVERY

The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care.

Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Any other visits or services within this time period should be coded separately.

Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. Medical problems complicating labor and delivery management may require additional resources and should be identified by utilizing the codes in the Medicine and E/M Services section in addition to codes for maternity care.

Postpartum care includes hospital and office visits following vaginal or cesarean section delivery.

For medical complications of pregnancy (eg, cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, pre-term labor, premature rupture of membranes), see services in the Medicine and E/M Services section. For surgical complications of pregnancy (eg, appendectomy, hernia, ovarian cyst, Bartholin cyst), see services in the Surgery section.

If a physician provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to termination of pregnancy by abortion or referral to another physician for delivery, see the antepartum and postpartum care codes 59425-59426 and 59430.

Reimbursement amounts for the Medicaid Obstetrical and Maternal Services Program (MOMS), are noted in the Enhanced Program excel Fee Schedule. For information on the MOMS Program, see Policy Section.

FETAL INVASIVE SERVICES

59000 Amniocentesis; diagnostic
59001 therapeutic amniotic fluid reduction (includes ultrasound guidance)
59012 Cordocentesis (intrauterine), any method
59015 Chorionic villus sampling, any method
59020 Fetal contraction stress test
59025 Fetal non-stress test
59030 Fetal scalp blood sampling
59050 Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation
59070 Transabdominal amnioinfusion, including ultrasound guidance
59072 Fetal umbilical cord occlusion, including ultrasound guidance
59074 Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance
59076 Fetal shunt placement, including ultrasound guidance

EXCISION

(For code 59135, See Rule 14, Receipt of Hysterectomy Information)

59100 Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)
(When tubal ligation is performed at the same time as hysterotomy, use 58611 in addition to 59100)
59120 Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach
59121 tubal or ovarian, without salpingectomy and/or oophorectomy
59130 abdominal pregnancy
59135 interstitial, uterine pregnancy requiring total hysterectomy
59136 interstitial, uterine pregnancy with partial resection of uterus
59140 cervical, with evacuation
59150 Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy
59151 with salpingectomy and/or oophorectomy
59160 Curettage, postpartum

INTRODUCTION

59200 Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)

REPAIR

59300 Episiotomy or vaginal repair, by other than attending
59320 Cerclage of cervix, during pregnancy; vaginal
59325 abdominal
59350 Hysterorrhaphy of ruptured uterus

VAGINAL DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

59400 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and **(inpatient and outpatient)** postpartum care (total, all-inclusive, "global" care)
59409 Vaginal delivery only (with or without episiotomy and/or forceps); (when only **inpatient** postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)
59410 including **(inpatient and outpatient)** postpartum care
59412 External cephalic version, with or without tocolysis
59414 Delivery of placenta (separate procedure)
(For antepartum care only, see 59425, 59426 or appropriate E/M code(s))
(For 1-3 antepartum care visits, see appropriate E/M code(s))
59425 Antepartum care only; 4-6 visits
59426 7 or more visits
(For 6 or less antepartum encounters, see code 59425)
Note: Antepartum services will no longer require prorated charges. This applies to all prenatal care providers, including those enrolled in the MOMS program. Providers should bill one unit of the appropriate antepartum code after all antepartum care has been rendered using the last antepartum visit as the date of service. Only one antepartum care code will be reimbursed per pregnancy.

59430 Postpartum care only (outpatient) (separate procedure)

CESAREAN DELIVERY

59510 Routine obstetric care including antepartum care, cesarean delivery, and (inpatient and outpatient) postpartum care (total, all-inclusive, "global" care)
59514 Cesarean delivery only; (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)
59515 including **(**inpatient and outpatient) postpartum care
59525 Subtotal or total hysterectomy after cesarean delivery **(See Rule 14)**
(List separately in addition to primary procedure)
(Use 59525 in conjunction with 59510, 59514, 59515, or 59618, 59620, 59622)

DELIVERY AFTER PREVIOUS CESAREAN DELIVERY

Patients who have had a previous cesarean delivery and now present with the expectation of a vaginal delivery are coded using codes 59610-59622. If the patient has a successful vaginal delivery after a previous cesarean delivery (VBAC), use codes 59610-59614. If the attempt is unsuccessful and another cesarean delivery is carried out, use codes 59618-59622. To report elective cesarean deliveries use code 59510, 59514 or 59515.

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and (inpatient and outpatient) postpartum care, after previous cesarean delivery (total, all-inclusive, "global" care)
59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)
59614 including (inpatient and outpatient) postpartum care
59618 Routine obstetric care including antepartum care, cesarean delivery, and (inpatient and outpatient) postpartum care, following attempted vaginal delivery after previous cesarean delivery (total, all-inclusive, "global" care)
59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)
59622 including (inpatient and outpatient) postpartum care

ABORTION

(Ultrasound service(s) provided in conjunction with procedure codes 59812 through 59857 are reimbursable **ONLY** via echography code 76815. Procedure code 76815 should be billed regardless of the approach used to perform the ultrasound (eg, transvaginal))

59812 Treatment of incomplete abortion, any trimester, completed surgically
59820 Treatment of missed abortion, completed surgically; first trimester
59821 second trimester
59830 Treatment of septic abortion, completed surgically

59840 Induced abortion, by dilation and curettage
59841 Induced abortion, by dilation and evacuation
59850 Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;
59851 with dilation and curettage and/or evacuation
59852 with hysterotomy (failed intra-amniotic injection)
59855 Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;
59856 with dilation and curettage and/or evacuation
59857 with hysterotomy (failed medical evaluation)

OTHER PROCEDURES

59870 Uterine evacuation and curettage for hydatidiform mole
59871 Removal of cerclage suture under anesthesia (other than local)
59897 Unlisted fetal invasive procedure, including ultrasound guidance, when performed
59898 Unlisted laparoscopy procedure, maternity care and delivery
59899 Unlisted procedure, maternity care and delivery

ENDOCRINE SYSTEM

THYROID GLAND

INCISION

60000 Incision and drainage of thyroglossal duct cyst, infected

EXCISION

60100 Biopsy thyroid, percutaneous core needle
60200 Excision of cyst or adenoma of thyroid, or transection of isthmus
60210 Partial thyroid lobectomy, unilateral; with or without isthmusectomy
60212 with contralateral subtotal lobectomy, including isthmusectomy
60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy
60225 with contralateral subtotal lobectomy, including isthmusectomy
60240 Thyroidectomy, total or complete
60252 Thyroidectomy, total or subtotal for malignancy; with limited neck dissection
60254 with radical neck dissection
60260 Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid
(For bilateral procedure, use modifier -50)
60270 Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach
60271 cervical approach
60280 Excision of thyroglossal duct cyst or sinus;
60281 recurrent

REMOVAL

60300 Aspiration and/or injection, thyroid cyst

PARATHYROID, THYMUS, ADRENAL GLANDS, PANCREAS, AND CARTOID BODY

EXCISION

60500 Parathyroidectomy or exploration of parathyroid(s);
60502 re-exploration
60505 with mediastinal exploration, sternal split or transthoracic approach
60512 Parathyroid autotransplantation
(List separately in addition to primary procedure)
(Use 60512 in conjunction with codes 60500, 60502, 60505, 60212, 60225, 60240, 60252, 60254, 60260, 60270, 60271)
60520 Thymectomy, partial or total; transcervical approach (separate procedure)
60521 sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)
60522 sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)
60540 Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure);
60545 with excision of adjacent retroperitoneal tumor
(For bilateral procedure, use modifier -50)
(For laparoscopic approach, use 60650)
60600 Excision of carotid body tumor; without excision of carotid artery
60605 with excision of carotid artery

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

60650 Laparoscopy, surgical; with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal
60659 Unlisted laparoscopy procedure, endocrine system

OTHER PROCEDURES

60699 Unlisted procedure, endocrine system

NERVOUS SYSTEM

SKULL, MENINGES, AND BRAIN

INJECTION, DRAINAGE OR ASPIRATION

61000 Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initial
61001 subsequent taps

61020 Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection
61026 with injection of medicament or other substance for diagnosis or treatment
61050 Cisternal or lateral cervical (CI-C2) puncture; without injection (separate procedure)
61055 with injection of medication or other substance for diagnosis or treatment
61070 Puncture of shunt tubing or reservoir for aspiration or injection procedure
(For radiological supervision and interpretation, use 75809)

TWIST DRILL, BURR HOLE(S) OR TREPHINE

(For codes 61107, 61210 for intracranial neuroendoscopic ventricular catheter placement, use 62160)

61105 Twist drill hole for subdural or ventricular puncture;
61107 Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for implanting ventricular catheter, pressure recording device, or other intracerebral monitoring device
61108 for evacuation and/or drainage of subdural hematoma
61120 Burr hole(s) for ventricular puncture (including injection of gas, contrast media, dye or radioactive material);
61140 Burr hole(s) or trephine; with biopsy of brain or intracranial lesion
61150 with drainage of brain abscess or cyst
61151 with subsequent tapping (aspiration) of intracranial abscess or cyst
61154 Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural
(For bilateral procedure, use modifier -50)
61156 Burr hole(s); with aspiration of hematoma or cyst, intracerebral
61210 for implanting ventricular catheter, reservoir, EEG electrode(s), pressure recording device, or other cerebral monitoring device (separate procedure)
61215 Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to ventricular catheter
61250 Burr hole(s) or trephine, supratentorial, exploratory, not followed by other surgery
(For bilateral procedure, use modifier -50)
61253 Burr hole(s) or trephine, infratentorial, unilateral or bilateral
(If burr hole(s) or trephine followed by craniotomy at same operative session use 61304-61321; do not use 61250 or 61253)

CRANIECTOMY OR CRANIOTOMY

61304 Craniectomy or craniotomy, exploratory; supratentorial
61305 infratentorial (posterior fossa)
61312 Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural
61313 intracerebral
61314 Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural
61315 intracerebellar
61316 Incision and subcutaneous placement of cranial bone graft
(List separately in addition to primary procedure)

(Use 61316 in conjunction with codes 61304, 61312, 61313, 61322, 61323, 61340, 61570, 61571, 61680-61705)

61320 Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial

61321 infratentorial

61322 Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy

61323 with lobectomy

(Do not report 61313 in addition to 61322, 61323)

61330 Decompression of orbit only, transcranial approach

(For bilateral procedure, use modifier -50)

61333 Exploration of orbit (transcranial approach) with removal of lesion

61340 Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome)

(For bilateral procedure, use modifier -50)

61343 Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft (eg, Arnold-Chiari malformation)

61345 Other cranial decompression, posterior fossa

61450 Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion

61458 Craniectomy, suboccipital; for exploration or decompression of cranial nerves

61460 for section of one or more cranial nerves

61500 Craniectomy; with excision of tumor or other bone lesion of skull

61501 for osteomyelitis

61510 Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma

61512 for excision of meningioma, supratentorial

61514 for excision of brain abscess, supratentorial

61516 for excision or fenestration of cyst, supratentorial

61517 Implantation of brain intracavitary chemotherapy agent

(List separately in addition to primary procedure)

(Use 61517 only in conjunction with codes 61510 or 61518)

(Do not report 61517 for brachytherapy insertion. For intracavitary insertion of radioelement sources or ribbons, see 77781-77784)

61518 Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull

61519 meningioma

61520 cerebellopontine angle tumor

61521 midline tumor at base of skull

61522 Craniectomy, infratentorial or posterior fossa; for excision of brain abscess

61524 for excision or fenestration of cyst

61526 Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;

61530 combined with middle/posterior fossa craniotomy/craniectomy

61531 Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring
61533 Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring
61534 for excision of epileptogenic focus without electrocorticography during surgery
61535 for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)
61536 for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)
61537 for lobectomy, temporal lobe, without electrocorticography during surgery
61538 for lobectomy, temporal lobe, with electrocorticography during surgery
61539 for lobectomy, other than temporal lobe, partial or total with electrocorticography during surgery
61540 for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery
61541 for transection of corpus callosum
61543 for partial or subtotal (functional) hemispherectomy
61544 for excision or coagulation of choroid plexus
61545 for excision of craniopharyngioma
61546 Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach
61548 Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic
61550 Craniectomy for craniosynostosis; single cranial suture
61552 multiple cranial sutures
61556 Craniotomy for craniosynostosis; frontal or parietal bone flap
61557 bifrontal bone flap
61558 Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); not requiring bone grafts
61559 recontouring with multiple osteotomies and bone autografts (eg, barrel-stave procedure) (includes obtaining grafts)
61563 Excision, intra- and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); without optic nerve decompression
61564 with optic nerve decompression
61566 Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy
61567 for multiple subpial transections, with electrocorticography during surgery
61570 Craniectomy or craniotomy; with excision of foreign body from brain
61571 with treatment of penetrating wound of brain
61575 Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion;
61576 requiring splitting of tongue and/or mandible (including tracheostomy)

SURGERY OF SKULL BASE

The surgical management of lesions involving the skull base (base of anterior, middle and posterior cranial fossae) often requires the skills of several surgeons of different surgical specialties working

together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of dura, subcutaneous tissues and skin to avoid serious infections such as osteomyelitis and/or meningitis.

The procedures are categorized according to 1) ***approach procedure*** necessary to obtain adequate exposure to the lesion (pathologic entity), 2) ***definitive procedure(s)*** necessary to biopsy, excise or otherwise treat the lesion, and 3) ***repair/reconstruction*** of the defect present following the definitive procedure(s).

The ***approach procedure*** is described according to anatomical area involved, ie, anterior cranial fossa, middle cranial fossa, posterior cranial fossa and brain stem or upper spinal cord.

The ***definitive procedure(s)*** describes the repair, biopsy, resection or excision of various lesions of the skull base and, when appropriate, primary closure of the dura, mucous membranes and skin.

The ***repair/reconstruction procedure(s)*** is reported separately if extensive dural grafting, cranioplasty, local or regional myocutaneous pedicle flaps, or extensive skin grafts are required.

When one surgeon performs the approach procedure, another surgeon performs the definitive procedure, and another surgeon performs the repair/reconstruction procedure, each surgeon reports only the code for the specific procedure performed.

APPROACH PROCEDURES

61580 Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration
61581 extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy
61582 extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa
61583 intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa
61584 Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); without orbital exenteration
61585 with orbital exenteration
61586 Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft
61590 Infratemporal pre-auricular approach to middle cranial fossa (parapharyngeal space, infratemporal and midline skull base, nasopharynx), with or without disarticulation of the mandible, including parotidectomy, craniotomy, decompression and/or mobilization of the facial nerve and/or petrous carotid artery
61591 Infratemporal post-auricular approach to middle cranial fossa (internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, infratemporal fossa) including mastoidectomy, resection of sigmoid sinus, with or without decompression and/or mobilization of contents of auditory canal or petrous carotid artery
61592 Orbitocranial zygomatic approach to middle cranial fossa (cavernous sinus and carotid artery, clivus, basilar artery or petrous apex) including osteotomy of zygoma, craniotomy, extra- or intradural elevation of temporal lobe

61595 Transtemporal approach to posterior cranial fossa, jugular foramen or midline skull base, including mastoidectomy, decompression of sigmoid sinus and/or facial nerve, with or without mobilization
61596 Transcochlear approach to posterior cranial fossa, jugular foramen or midline skull base, including labyrinthectomy, decompression, with or without mobilization of facial nerve and/or petrous carotid artery
61597 Transcondylar (far lateral) approach to posterior cranial fossa, jugular foramen or midline skull base including occipital condylectomy, mastoidectomy, resection of Cl-C3 vertebral body(s), decompression of vertebral artery, with or without mobilization
61598 Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus

DEFINITIVE PROCEDURES

61600 Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; extradural
61601 intradural, including dural repair, with or without graft
61605 Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural
61606 intradural, including dural repair, with or without graft
61607 Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural
61608 intradural, including dural repair, with or without graft

61611 Transection or ligation, carotid artery in petrous canal; without repair
(List separately in addition to primary procedure)

61613 Obliteration of carotid aneurysm, arteriovenous malformation, or carotid-cavernous fistula by dissection within cavernous sinus
61615 Resection or excision of neoplastic vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or Cl-C3 vertebral bodies; extradural
61616 intradural, including dural repair, with or without graft

REPAIR AND/OR RECONSTRUCTION OF SURGICAL DEFECTS OF SKULL BASE

61618 Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by free tissue graft (eg, pericranium, fascia, tensor fascia lata, adipose tissue, homologous or synthetic grafts)
61619 by local or regionalized vascularized pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle)

ENDOVASCULAR THERAPY

61623 Endovascular temporary balloon arterial occlusion, head or neck (extracranial/intracranial) including selective catheterization of vessel to be occluded, positioning and inflation of occlusion balloon, concomitant neurological monitoring, and radiologic supervision and

interpretation of all angiography required for balloon occlusion and to exclude vascular injury post occlusion

61624 Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)
(See also 37204)

61626 non-central nervous system, head or neck (extracranial, brachiocephalic branch)
(See also 37204)

61630 Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous

61635 Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed
(61630 and 61635 include all selective vascular catheterization of the target vascular family, all diagnostic imaging for arteriography of the target vascular family, and all related radiological supervision and interpretation. When diagnostic arteriogram (including imaging and selective catheterization) confirms the need for angioplasty or stent placement, 61630 and 61635 are inclusive of these services. If angioplasty or stenting are not indicated, then the appropriate codes for selective catheterization and imaging should be reported in lieu of 61630 and 61635)

61640 Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel

61641 each additional vessel in same vascular territory
(List separately in addition to primary procedure)

61642 each additional vessel in different vascular territory
(List separately in addition to primary procedure)
(Use 61641 and 61642 in conjunction with 61640)
(61640, 61641, 61642 include all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, postdilatation angiography, and fluoroscopic guidance for the balloon dilatation)

61645 Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)

61650 Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory

61651 each additional vascular territory (List separately in addition to code for primary procedure)
(Do not report 61650 or 61651 in conjunction with 36221, 36222, 36223, 36224, 36225, 36226, 61640, 61641, 61642, 61645 for the same vascular territory)
(Do not report 61650 or 61651 in conjunction with 96420, 96422, 96423, 96425 for the same vascular territory)

SURGERY FOR ANEURYSM, ARTERIOVENOUS MALFORMATION OR VASCULAR DISEASE

Includes craniotomy when appropriate for procedure.

61680 Surgery of intracranial arteriovenous malformation; supratentorial, simple

61682 supratentorial, complex

61684 infratentorial, simple

61686 infratentorial, complex
61690 dural, simple
61692 dural, complex
61697 Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation
61698 vertebrobasilar circulation
(61697, 61698 involve aneurysms that are larger than 15 mm or with calcification of the aneurysm neck, or with incorporation of normal vessels into the aneurysm neck, or a procedure requiring temporary vessel occlusion, trapping or cardiopulmonary bypass to successfully treat the aneurysm)
61700 Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation
61702 vertebrobasilar circulation
61703 Surgery of intracranial aneurysm, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type)
61705 Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery
61708 by intracranial electrothrombosis
61710 by intra-arterial embolization, injection procedure, or balloon catheter
61711 Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical) arteries

STEREOTAXIS

Coverage for 61781-61783 Stereotactic Computer-Assisted Volumetric (Navigational) Procedures is allowed only under the following conditions:

Procedure to be performed as a pre-surgical assessment and/or intraoperative assessment, in preparation for, and execution of planned craniotomy (CPT codes 61304-61576), along with a diagnosis of arteriovenous malformation of brain, malignant or benign neoplasm of the brain, or intractable epilepsy.

61720 Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus
61735 subcortical structure(s) other than globus pallidus or thalamus
61750 Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion;
61751 with computed tomography and/or magnetic resonance guidance
61760 Stereotactic implantation of depth electrodes into the cerebrum for long term seizure monitoring
61770 Stereotactic localization, including burr hole(s); with insertion of catheter(s) or probe(s) for placement of radiation source
61781 Stereotactic computer-assisted (navigational) procedure; cranial, intradural
(List separately in addition to primary procedure)
61782 cranial, extradural
(List separately in addition to primary procedure)
61783 spinal
(List separately in addition to primary procedure)
61790 Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); gasserian ganglion

61791 trigeminal medullary tract

STEREOTACTIC RADIOSURGERY (CRANIAL)

61796 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion
(Do not report 61796 more than once per course of treatment)
(Do not report 61796 in conjunction with 61798)

61797 each additional cranial lesion, simple
(List separately in addition to primary procedure)
(Use 61797 in conjunction with 61796, 61798)
(For each course of treatment, 61797 and 61799 may be reported no more than once per lesion. Do not report any combination of 61797 and 61799 more than 4 times for entire course of treatment regardless of number of lesions treated)

61798 1 complex cranial lesion
(Do not report 61798 more than once per course of treatment)
(Do not report 61798 in conjunction with 61796)

61799 each additional cranial lesion, complex
(List separately in addition to primary procedure)
(Use 61799 in conjunction with 61798)
(For each course of treatment, 61797 and 61799 may be reported no more than once per lesion. Do not report any combination of 61797 and 61799 more than 4 times for entire course of treatment regardless of number of lesions treated)

61800 Application of stereotactic headframe for stereotactic radiosurgery
(List separately in addition to primary procedure)
(Use 61800 in conjunction with 61796, 61798)

NEUROSTIMULATORS (INTRACRANIAL)

Codes 61850-61888 apply to both simple and complex neurostimulators. For initial or subsequent electronic analysis and programming of neurostimulator pulse generators, see codes 95970-95975.

Microelectrode recording, when performed by the operating surgeon in association with implantation of neurostimulator electrode arrays, is an inclusive service and should not be reported separately. If another physician participates in neurophysiological mapping during a deep brain stimulator implantation procedure, this service may be reported by the other physician with codes 95961-95962.

61850 Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical

61860 Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral; cortical

61863 Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array

61864 each additional array
(List separately in addition to primary procedure)
(Use 61864 in conjunction with 61863)

61867 Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array
61868 each additional array
(List separately in addition to primary procedure)
(Use 61868 in conjunction with 61867)
61880 Revision or removal of intracranial neurostimulator electrodes
61885 Incision or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886 with connection to two or more electrode arrays
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)

REPAIR

62000 Elevation of depressed skull fracture; simple, extradural
62005 compound or comminuted, extradural
62010 with repair of dura and/or debridement of brain
62100 Craniotomy for repair of dural/cerebrospinal fluid leak, including surgery for rhinorrhea/otorrhea
62115 Reduction of craniomegalic skull (eg, treated hydrocephalus); not requiring bone grafts or cranioplasty
62117 requiring craniotomy and reconstruction with or without bone graft
(includes obtaining grafts)
62120 Repair of encephalocele, skull vault, including cranioplasty
62121 Craniotomy for repair of encephalocele, skull base
62140 Cranioplasty for skull defect; up to 5 cm diameter
62141 larger than 5 cm diameter
62142 Removal of bone flap or prosthetic plate of skull
62143 Replacement of bone flap or prosthetic plate of skull
62145 Cranioplasty for skull defect with reparative brain surgery
62146 Cranioplasty with autograft (includes obtaining bone grafts); up to 5 cm diameter
62147 larger than 5 cm diameter
62148 Incision and retrieval of subcutaneous cranial bone graft for cranioplasty
(List separately in addition to primary procedure)
(Use 62148 in conjunction with codes 62140-62147)

NEUROENDOSCOPY

Surgical endoscopy always includes diagnostic endoscopy.

62160 Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage
(List separately in addition to primary procedure)
(Use 62160 only in conjunction with codes 61107, 61210, 62220, 62223, 62225 or 62230)

62161 Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter)
62162 with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage
62164 with excision of brain tumor, including placement of external ventricular catheter for drainage
62165 with excision of pituitary tumor, transnasal or trans-sphenoidal approach

CEREBROSPINAL FLUID (CSF) SHUNT

(For codes 62220, 62223, 62225, 62230, 62258, for intracranial neuroendoscopic ventricular catheter placement, use 62160)

62180 Ventriculocisternostomy (Torkildsen type operation)
62190 Creation of shunt; subarachnoid/subdural-atrial, -jugular, -auricular
62192 subarachnoid/subdural-peritoneal, -pleural, -other terminus
62194 Replacement or irrigation, subarachnoid/subdural catheter
62200 Ventriculocisternostomy, third ventricle
62201 stereotactic, neuroendoscopic method
62220 Creation of shunt; ventriculo-atrial, -jugular, -auricular
62223 ventriculo-peritoneal, -pleural, -other terminus
62225 Replacement or irrigation, ventricular catheter
62230 Replacement or revision of cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system
62252 Reprogramming of programmable cerebrospinal fluid shunt
62256 Removal of complete cerebrospinal fluid shunt system; without replacement
62258 with replacement by similar or other shunt at same operation

SPINE AND SPINAL CORD

INJECTION, DRAINAGE OR ASPIRATION

Injection of contrast during fluoroscopic guidance and localization is an inclusive component of codes 62263-62264, 62267, 62270-62273, 62280-62282. Fluoroscopic guidance and localization is reported by code 77003, unless a formal contrast study (myelography, epidurography, or arthrography) is performed, in which case the use of fluoroscopy is included in the supervision and interpretation codes.

Code 62263 describes a catheter-based treatment involving targeted injection of various substances (eg, hypertonic saline, steroid, anesthetic) via an indwelling epidural catheter. Code 62263 includes percutaneous insertion and removal of an epidural catheter (remaining in place over a several-day period), for the administration of multiple injections of a neurolytic agent(s) performed during serial treatment sessions (ie, spanning two or more treatment days). If required, adhesions or scarring may also be lysed by mechanical means. Code 62263 is NOT reported for each adhesiolysis treatment, but should be reported ONCE to describe the entire series of injections/infusions spanning two or more treatment days.

Code 62264 describes multiple adhesiolysis treatment sessions performed on the same day. Adhesions or scarring may be lysed by injections of neurolytic agent(s). If required, adhesions or scarring may also be lysed mechanically using a percutaneously-depolyed catheter.

Codes 62263 and 62264 include the procedure of injections of contrast for epidurography (72275) and fluoroscopic guidance and localization (77003) during initial or subsequent sessions.

62263 Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264 1 day
(Do not report 62264 with 62263)
(62263 and 62264 include codes 72275 and 77003)
62267 Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes
(Do not report 62267 in conjunction with 20225, 62287, 62290, 62291)
62268 Percutaneous aspiration, spinal cord cyst or syrinx
62269 Biopsy of spinal cord, percutaneous needle
62270 Spinal puncture, lumbar, diagnostic
62328 with fluoroscopic or CT guidance
62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)
62329 with fluoroscopic or CT guidance
62273 Injection, epidural, of blood or clot patch
62280 Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions) with or without other therapeutic substance; subarachnoid
62281 epidural, cervical or thoracic
62282 epidural, lumbar, sacral (caudal)
62284 Injection procedure for myelography and/or computed tomography, lumbar (other than C1-C2 and posterior fossa)
62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar
62290 Injection procedure for discography, each level; lumbar
62291 cervical or thoracic
62292 Injection procedure for chemonucleolysis, including discography, intervertebral disk, single or multiple levels, lumbar
62294 Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal
62302 Myelography via lumbar injection, including radiological supervision and interpretation; cervical
62303 thoracic
62304 lumbosacral
62305 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)
62320 Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic

opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidual or subarachnoid, cervical or thoracic; without imaging guidance

62321 with imaging guidance (ie, fluoroscopy or CT)

62322 Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidual or subarachnoid, lumbar or sacral (caudal); without imaging guidance

62323 with imaging guidance (ie, fluoroscopy or CT)

62324 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic opioid, steroid, other solution), not including neurolytic substances, interlaminar epidual or subarachnoid, cervical or thoracic; without imaging guidance

62325 with imaging guidance (ie, fluoroscopy or CT)

62326 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic opioid, steroid, other solution), not including neurolytic substances, interlaminar epidual or subarachnoid, lumbar or sacral (caudal); without imaging guidance

62327 with imaging guidance (ie, fluoroscopy or CT)

CATHETER IMPLANTATION

62350 Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir infusion pump; without laminectomy

62351 with laminectomy

62355 Removal of previously implanted intrathecal or epidural catheter

RESERVOIR/PUMP IMPLANTATION

62360 Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir

62361 nonprogrammable pump

62362 programmable pump, including preparation of pump, with or without programming

62365 Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion

62367 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill

62368 with reprogramming

62370 with reprogramming and refill (requiring skill of a physician or other qualified health care professional)

(Do not report 62367-62370 in conjunction with 95900, 95991)

POSTERIOR EXTRADURAL LAMINOTOMY OR LAMINECTOMY FOR EXPLORATION/ DECOMPRESSION OF NEURAL ELEMENTS OR EXCISION OF HERNIATED INTERVERTEBRAL DISKS

(For bilateral procedure report 63020, 63030, 63035, 63040, 63042, 63043, 63044 with modifier 50)

63001 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), one or two vertebral segments; cervical
63003 thoracic
63005 lumbar, except for spondylolisthesis
63011 sacral
63012 Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63015 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg. spinal stenosis), more than 2 vertebral segments; cervical
63016 thoracic
63017 lumbar
63020 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63030 1 interspace, lumbar
63035 each additional interspace, cervical or lumbar
(List separately in addition to primary procedure)
(Use 63035 in conjunction with 63020-63030)
63040 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; cervical
63042 lumbar
63043 each additional cervical interspace
(List separately in addition to primary procedure)
(Use 63043 in conjunction with 63040)
63044 each additional lumbar interspace
(List separately in addition to primary procedure)
(Use 63044 in conjunction with code 63042)
63045 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; cervical
63046 thoracic
63047 lumbar
63048 each additional segment, cervical thoracic or lumbar
(List separately in addition to primary procedure)
(Use 63048 in conjunction with codes 63045-63047)

63050 Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments;

63051 with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)

(Do not report 63050 or 63051 in conjunction with 22600, 22614, 22840-22842, 63001, 63015, 63045, 63048, 63295 for the same vertebral segment(s))

TRANSPEDICULAR OR COSTOVERTEBRAL APPROACH FOR POSTEROLATERAL EXTRADURAL EXPLORATION/DECOMPRESSION

63055 Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disk), single segment; thoracic

63056 lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disk)

63057 each additional segment, thoracic or lumbar
(List separately in addition to primary procedure)
(Use 63057 in conjunction with codes 63055, 63056)

63064 Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic; single segment

63066 each additional segment
(List separately in addition to primary procedure)
(Use 63066 in conjunction with code 63064)

ANTERIOR OR ANTEROLATERAL APPROACH FOR EXTRADURAL EXPLORATION/DECOMPRESSION

For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of spinal cord exploration/decompression operation, append modifier -62 to the procedure code (and any associated add-on codes for that procedure code as long as both surgeons continue to work together as primary surgeons). One surgeon should file one claim line representing the procedure performed by the two surgeons.

In this situation, modifier -62 may be appended to the definitive procedure code(s) 63075, 63077, 63081, 63085, 63087, 63090 and, as appropriate, to associated additional interspace add-on code(s) 63076, 63078 or additional segment add-on code(s) 63082, 63086, 63088, 63091 as long as both surgeons continue to work together as primary surgeons.

63075 Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace

63076 cervical, each additional interspace
(List separately in addition to primary procedure)
(Use 63076 in conjunction with 63075)

63077 thoracic, single interspace

63078 thoracic, each additional interspace
(List separately in addition to primary procedure)
(Use 63078 in conjunction with 63077)

63081 Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082 cervical, each additional segment
(List separately in addition to primary procedure)
(Use 63082 in conjunction with 63081)
63085 Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment
63086 thoracic, each additional segment
(List separately in addition to primary procedure)
(Use 63086 in conjunction with 63085)
63087 Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment
63088 each additional segment
(List separately in addition to primary procedure)
(Use 63088 in conjunction with 63087)
63090 Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment
63091 each additional segment
(List separately in addition to primary procedure)
(Use 63091 in conjunction with 63090)
(Procedures 63081-63091 include discectomy above and/or below vertebral segment)

LATERAL EXTRACAVITARY APPROACH FOR EXTRADURAL EXPLORATION/DECOMPRESSION

63101 Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment
63102 lumbar, single segment
63103 thoracic or lumbar, each additional segment
(List separately in addition to primary procedure)
(Use 63103 in conjunction with 63101 and 63102)

INCISION

63170 Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic or thoracolumbar
63172 Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid space
63173 to peritoneal or pleural space
63185 Laminectomy with rhizotomy; one or two segments
63190 more than two segments
63191 Laminectomy with section of spinal accessory nerve
(For bilateral procedure, use modifier -50)
63194 Laminectomy with cordotomy, with section of one spinothalamic tract, one stage; cervical
63195 thoracic

63196 Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage; cervical
63197 thoracic
63198 Laminectomy with cordotomy, with section of both spinothalamic tracts, two stages within 14 days; cervical
63199 thoracic
63200 Laminectomy, with release of tethered spinal cord, lumbar

EXCISION BY LAMINECTONY OF LESION OTHER THAN HERNIATED DISK

63250 Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical
63251 thoracic
63252 thoracolumbar
63265 Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
63266 thoracic
63267 lumbar
63268 sacral
63270 Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical
63271 thoracic
63272 lumbar
63273 sacral
63275 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical
63276 extradural, thoracic
63277 extradural, lumbar
63278 extradural, sacral
63280 intradural, extramedullary, cervical
63281 intradural, extramedullary, thoracic
63282 intradural, extramedullary, lumbar
63283 intradural, sacral
63285 intradural, intramedullary, cervical
63286 intradural, intramedullary, thoracic
63287 intradural, intramedullary, thoracolumbar
63290 combined extradural-intradural lesion, any level
63295 Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to primary procedure)
(Use 63295 in conjunction with 63172, 63173, 63185, 63190, 63200-63290)
(Do not report 63295 in conjunction with 22590-22614, 22840-22844, 63050, 63051 for the same vertebral segment(s))

EXCISION, ANTERIOR OR ANTEROLATERAL APPROACH, INTRASPINAL LESION

For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of an anterior approach for an intraspinal excision, append modifier -62 to the single definitive procedure code. One surgeon should file one claim line representing the procedure performed by the two surgeons. In this situation, modifier 62 may be appended to the definitive procedure code(s)

63300-63307 and, as appropriate, to the associated additional segment add-on code 63308 as long as both surgeons continue to work together as primary surgeons.

63300 Vertebral corpectomy (vertebral body resection), partial or complete for excision of intraspinal lesion, single segment; extradural, cervical
63301 extradural, thoracic by transthoracic approach
63302 extradural, thoracic by thoracolumbar approach
63303 extradural, lumbar or sacral by transperitoneal or retroperitoneal approach
63304 intradural, cervical
63305 intradural, thoracic by transthoracic approach
63306 intradural, thoracic by thoracolumbar approach
63307 intradural, lumbar or sacral by transperitoneal or retroperitoneal approach
63308 each additional segment
(List separately in addition to codes for single segment)
(Use in conjunction with 63300-63307)

STEREOTAXIS

63600 Creation of lesion of spinal cord by stereotactic method, percutaneous, any modality (including stimulation and/or recording)
63610 Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery

STEREOTACTIC RADIOSURGERY (SPINAL)

63620 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion
(Do not report 63620 more than once per course of treatment)
63621 each additional spinal lesion
(List separately in addition to primary procedure)
(Report 63621 in conjunction with 63620)
(For each course of treatment, 63621 may be reported no more than once per lesion. Do not report 63621 more than 2 times for entire course of treatment regardless of number of lesions treated)

NEUROSTIMULATORS (SPINAL)

Codes 63650-63688 apply to both simple and complex neurostimulators. For initial or subsequent electronic analysis and programming of neurostimulator pulse generators, see codes 95970-95975.

Codes 63650, 63655, and 63661-63664 describe the operative placement, revision, or removal of the spinal neurostimulator system components to provide spinal electrical stimulation. A neurostimulator system includes an implanted neurostimulator, external controller, extension, and collection of contacts. Multiple contacts or electrodes (4 or more) provide the actual electrical stimulation in the epidural space.

For percutaneously placed neurostimulator systems (63650, 63661, 63663) the contacts are on a catheter-like lead. An array defines the collection of contacts that are on one catheter.

For systems placed via an open surgical exposure (63655, 63662, 63664) the contacts are on a plate or paddle-shaped surface.

63650 Percutaneous implantation of neurostimulator electrode array, epidural
63655 Laminectomy for implantation of neurostimulator electrodes plate/paddle, epidural
63661 Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63662 Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63663 Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
(Do not report 63663 in conjunction with 63661, 63662 for the same spinal level)
63664 Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
(Do not report 63664 in conjunction with 63661, 63662 for the same spinal level)
63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
(Do not report 63685 in conjunction with 63688 for the same pulse generator or receiver)
63688 Revision or removal of implanted spinal neurostimulator pulse generator or receiver

REPAIR

(Do not use modifier –63 in conjunction with 63700-63706)

63700 Repair of meningocele; less than 5 cm diameter
63702 larger than 5 cm diameter
63704 Repair of myelomeningocele; less than 5 cm diameter
63706 larger than 5 cm diameter
63707 Repair of dural/cerebrospinal fluid leak, not requiring laminectomy
63709 Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy
63710 Dural graft, spinal

SHUNT, SPINAL CSF

63740 Creation of shunt, lumbar, subarachnoid- peritoneal, -pleural, or other; including laminectomy
63741 percutaneous, not requiring laminectomy
63744 Replacement, irrigation or revision of lumbosubarachnoid shunt
63746 Removal of entire lumbosubarachnoid shunt system without replacement

EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM

INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC:

SOMATIC NERVES

64400 Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular
64405 greater occipital nerve
64408 vagus nerve
64415 brachial plexus
64416 brachial plexus, continuous infusion by catheter (including catheter placement)
64417 axillary nerve
64418 suprascapular nerve
64420 intercostal nerve, single level
64421 intercostal nerve, each additional level
64425 ilioinguinal, iliohypogastric nerves
64430 pudendal nerve
64435 paracervical (uterine) nerve
64445 sciatic nerve,
64446 sciatic nerve, continuous infusion by catheter, (including catheter placement)
64447 femoral nerve
64448 femoral nerve, continuous infusion by catheter, (including catheter placement)
64449 lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)
64450 other peripheral nerve or branch
64451 nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
64454 genicular nerve branches, including imaging guidance, when performed.
64455 plantar common digital nerve(s) (eg, Morton's neuroma)
(Do not report 64455 in conjunction with 64632)
64479 transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level
64480 transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level
(List separately in additiona to code for primary procedure)
(Use 64480 in conjunction with 64479)
(For transforaminal epidural injection at the T12-L1 level, use 64479)
64483 transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level
64484 transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level
(List separately in addition to primary procedure)
(Use 64484 in conjunction with 64483)
64461 Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed) (Report Required)
64462 second and any additional injection site(s) (includes imaging guidance when performed)
(List separately in addition to code for primary procedure) (Report required)
(Do not report 64462 more than once per day)

64463 continuous infusion by catheter (includes imaging guidance when performed) (Report required)
64486 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance ,when performed)
64487 by continuous infusion(s) (includes imaging guidance, when performed)
64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)
64489 by continuous infusions (includes imaging guidance, when performed)
64490 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), cervical or thoracic; single level
64491 second level
(List separately in addition to primary procedure)
64492 third and any additional level(s)
(List separately in addition to primary procedure)
64493 lumbar or sacral; single level
64494 second level
(List separately in addition to primary procedure)
64495 third and any additional level(s)
(List separately in addition to primary procedure)
(Do not report 64495 more than once per day)

SYMPATHETIC NERVES

64505 Injection, anesthetic agent; sphenopalatine ganglion
64510 stellate ganglion (cervical sympathetic)
64517 superior hypogastric plexus
64520 lumbar or thoracic (paravertebral sympathetic)
64530 celiac plexus, with or without radiologic monitoring

NEUROSTIMULATORS (PERIPHERAL NERVE)

Codes 64553-64595 apply to both simple and complex neurostimulators. For initial or subsequent electronic analysis and programming of neurostimulator pulse generators, see codes 95970-95975.

64553 Percutaneous implantation of neurostimulator electrode array; cranial nerve
64555 peripheral nerve (excludes sacral nerve)
(Do not report 64555 in conjunction with 64566)
64561 sacral nerve (transforaminal placement) including image guidance, if performed
64566 Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming

(Do not report 64566 in conjunction with 64555, 95970-95972)
64568 Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
(Do not report 64568 in conjunction with 61885, 61886, 64570)
64569 Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
(Do not report 64569 in conjunction with 64570 or 61888)
64570 Removal of cranial nerve (eg. vagus nerve) neurostimulator electrode array and pulse generator
(Do not report 64570 in conjunction with 61888)
64575 Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64580 neuromuscular
64581 sacral nerve (transforaminal placement)
64585 Revision or removal of peripheral neurostimulator electrode array
64590 Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
(Do not report 64590 in conjunction with 64595)
64595 Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver

DESTRUCTION BY NEUROLYTIC AGENT (EG, CHEMICAL, THERMAL, ELECTRICAL, RADIOFREOUENCY)

Codes 64600-64681 include the injection of other therapeutic agents (eg, corticosteroids).

SOMATIC NERVES

64600 Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
64605 second and third division branches at foramen ovale
64610 second and third division branches at foramen ovale under radiologic monitoring
64611 Chemodenervation of parotid and submandibular salivary glands, bilateral
64612 Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)
64615 muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
64616 neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis
64617 larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed
64620 Destruction by neurolytic agent; intercostal nerve
64630 Destruction by neurolytic agent; pudendal nerve
64632 plantar common digital nerve
(Do not report 64632 in conjunction with 64455)

64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634 cervical or thoracic, each additional facet joint
(List separately in addition to primary procedure)
(Use 64634 in conjunction with 64633)
64635 lumbar or sacral, single facet joint
64636 lumbar or sacral, each additional facet joint
(List separately in addition to primary procedure)
(Use 64636 in conjunction with 64635)
(Do not report 64633-64636 in conjunction with 77003, 77012)
(For bilateral procedure, report 64633-64636 with modifier 50)
64640 other peripheral nerve or branch
64642 Chemodenervation of one extremity; 1-4 muscle(s)
64643 each additional extremity; 1-4 muscle(s) (List separately in addition to code for primary procedure)
64644 Chemodenervation of one extremity; 5 or more muscle(s)
64645 each additional extremity; 5 or more muscle(s) (List separately in addition to code for primary procedure)
64646 Chemodenervation of trunk muscle(s); 1-5 muscle(s)
64647 6 or more muscle(s)

SYMPATHETIC NERVES

64650 Chemodenervation of eccrine glands; both axillae
64653 other area(s) (eg, scalp, face, neck), per day
64680 Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus
64681 superior hypogastric plexus

NEUROPLASTY (EXPLORATION, NEUROLYSIS OR NERVE DECOMPRESSION)

Neuroplasty is the decompression or freeing of intact nerve from scar tissue, including external neurolysis and/or transposition.

64702 Neuroplasty; digital, one or both, same digit
64704 nerve of hand or foot
64708 Neuroplasty, major peripheral nerve, arm or leg, open; other than specified
64712 sciatic nerve
64713 brachial plexus
64714 lumbar plexus
64716 Neuroplasty and/or transposition; cranial nerve (specify)
64718 ulnar nerve at elbow
64719 ulnar nerve at wrist
64721 median nerve at carpal tunnel
64722 Decompression; unspecified nerve(s) (specify)
64726 plantar digital nerve
64727 Internal neurolysis, requiring use of operating microscope

(List separately in addition to code for neuroplasty)
(Neuroplasty includes external neurolysis)

TRANSECTION OR AVULSION

64732 Transection or avulsion of; supraorbital nerve
64734 infraorbital nerve
64736 mental nerve
64738 inferior alveolar nerve by osteotomy
64740 lingual nerve
64742 facial nerve, differential or complete
64744 greater occipital nerve
64746 phrenic nerve
64755 vagus nerve limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy)
64760 vagus nerve (vagotomy), abdominal
64763 Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy
64766 Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy
64771 Transection or avulsion of other cranial nerve, extradural
(For procedures 64763, 64766, for bilateral procedure, use modifier -50)
64772 Transection or avulsion of other spinal nerve, extradural

EXCISION

SOMATIC NERVES

64774 Excision of neuroma; cutaneous nerve, surgically identifiable
64776 digital nerve, one or both, same digit
64778 digital nerve, each additional digit
(List separately in addition to primary procedure)
(Use 64778 in conjunction with 64776)
64782 hand or foot, except digital nerve
64783 hand or foot, each additional nerve, except same digit
(List separately in addition to primary procedure)
(Use 64783 in conjunction with 64782)
64784 major peripheral nerve, except sciatic
64786 sciatic nerve
64787 Implantation of nerve end into bone or muscle
(List separately in addition to neuroma excision)
(Use 64787 in conjunction with 64774-64786)
64788 Excision of neurofibroma or neurolemmoma; cutaneous nerve
64790 major peripheral nerve
64792 extensive (including malignant type)
64795 Biopsy of nerve

SYMPATHETIC NERVES

(For procedures 64802, 64804, 64809, 64818 for bilateral procedure, use modifier -50)

64802 Sympathectomy, cervical
64804 cervicothoracic
64809 thoracolumbar
64818 lumbar
64820 digital arteries, each digit
64821 radial artery
64822 ulnar artery
64823 superficial palmar arch

NEURORRHAPHY

64831 Suture of digital nerve, hand or foot; one nerve
64832 each additional digital nerve
(List separately in addition to primary procedure)
(Use 64832 in conjunction with 64831)
64834 Suture of one nerve; hand or foot, common sensory nerve
64835 median motor thenar
64836 ulnar motor
64837 Suture of each additional nerve, hand or foot
(List separately in addition to primary procedure)
(Use 64837 in conjunction with 64834-64836)
64840 Suture of posterior tibial nerve
64856 Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64857 without transposition
64858 Suture of sciatic nerve
64859 Suture of each additional major peripheral nerve
(List separately in addition to primary procedure)
(Use 64859 in conjunction with 64856, 64857)
64861 Suture of; brachial plexus
64862 lumbar plexus
64864 Suture of facial nerve; extracranial
64865 infratemporal, with or without grafting
64866 Anastomosis; facial-spinal accessory
64868 facial-hypoglossal
64872 Suture of nerve; requiring secondary or delayed suture
(List separately in addition to primary neurorrhaphy)
64874 requiring extensive mobilization, or transposition of nerve
(List separately in addition to code for nerve suture)
64876 requiring shortening of bone of extremity
(List separately in addition to code for nerve suture)
(Use 64872, 64874, 64876 in conjunction with 64831-64865)

NEURORRHAPHY WITH NERVE GRAFT, VEIN GRAFT, OR CONDUIT

64885 Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length
64886 more than 4 cm in length
64890 Nerve graft (includes obtaining graft), single strand hand or foot; up to 4 cm length
64891 more than 4 cm length
64892 Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64893 more than 4 cm length
64895 Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length
64896 more than 4 cm length
64897 Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm. length
64898 more than 4 cm length
64901 Nerve graft, each additional nerve; single strand
(List separately in addition to primary procedure)
(Use 64901 in conjunction with 64885-64893)
64902 multiple strands (cable)
(List separately in addition to primary procedure)
(Use 64902 in conjunction with 64885, 64886, 64895-64898)
64905 Nerve pedicle transfer; first stage
64907 second stage
64910 Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve
64911 with autogenous vein graft (includes harvest of vein graft), each nerve

OTHER PROCEDURES

64999 Unlisted procedure, nervous system

EYE AND OCULAR ADNEXA

(For diagnostic and treatment ophthalmological services, see MEDICINE, Ophthalmology, and 92002 et seq)

EYEBALL

REMOVAL OF EYE

65091 Evisceration of ocular contents; without implant
65093 with implant
65101 Enucleation of eye; without implant
65103 with implant, muscles not attached to implant
65105 with implant, muscles attached to implant
65110 Exenteration of orbit (does not include skin graft), removal of orbital contents; only
65112 with therapeutic removal of bone
65114 with muscle or myocutaneous flap

SECONDARY IMPLANT(S) PROCEDURES

An ocular implant is an implant inside muscular cone; an orbital implant is an implant outside muscular cone.

65125 Modification of ocular implant with placement or replacement of pegs (eg, drilling receptacle for prosthesis appendage) (separate procedure)
65130 Insertion of ocular implant secondary; after evisceration, in scleral shell
65135 after enucleation, muscles not attached to implant
65140 after enucleation, muscles attached to implant
65150 Reinsertion of ocular implant; with or without conjunctival graft
65155 with use of foreign material for reinforcement and/or attachment of muscles to implant
65175 Removal of ocular implant

REMOVAL OF FOREIGN BODY

65205 Removal of foreign body, external eye; conjunctival superficial
65210 conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
65220 corneal, without slit lamp
65222 corneal, with slit lamp
65235 Removal of foreign body, intraocular; from anterior chamber of eye or lens
65260 from posterior segment, magnetic extraction, anterior or posterior route
65265 from posterior segment, nonmagnetic extraction

REPAIR OF LACERATION

65270 Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure
65272 conjunctiva, by mobilization and rearrangement, without hospitalization
65273 conjunctiva, by mobilization and rearrangement, with hospitalization
65275 cornea, nonperforating, with or without removal foreign body
65280 cornea and/or sclera, perforating, not involving uveal tissue
65285 cornea and/or sclera, perforating, with reposition or resection of uveal tissue
65286 application of tissue glue, wounds of cornea and/or sclera
65290 Repair of wound, extraocular muscle, tendon and/or Tenon's capsule

ANTERIOR SEGMENT

CORNEA

EXCISION

65400 Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium
65410 Biopsy of cornea
65420 Excision or transposition of pterygium; without graft
65426 with graft

REMOVAL OR DESTRUCTION

65430 Scraping of cornea, diagnostic, for smear and/or culture

65435 Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)
65436 with application of chelating agent, eg, EDTA
65450 Destruction of lesion of cornea by cryotherapy, photocoagulation or thermocauterization
65600 Multiple punctures of anterior cornea (eg, for corneal erosion, tattoo)

KERATOPLASTY

Corneal transplant includes use of fresh or preserved grafts, and preparation of donor material. (Keratoplasty excludes refractive keratoplasty procedures 65760, 65765 and 65767)

65710 Keratoplasty (corneal transplant); anterior lamellar
65730 penetrating (except in aphakia or pseudophakia)
65750 penetrating (in aphakia)
65755 penetrating (in pseudophakia)
65756 endothelial

OTHER PROCEDURES

65778, 65779, 65780, 65781, 65782 are billable for patients with ocular surface deficiency, for those patients: who have sustained ocular burns and/or injuries OR; who have ocular complications secondary to Stevens-Johnson syndrome OR; who have undergone multiple surgeries or cryotherapies to the limbal region OR; who require these reconstructive procedures in addition to NYS Medicaid covered keratoplasty procedures OR; for whom medical management (lubricants, artificial tears, topical and systemic antibiotics, topical and systemic steroids, patches, etc.) has proven ineffective.

65760 Keratomileusis
65765 Keratophakia
65767 Epikeratoplasty
65770 Keratoprosthesis
65771 Radial keratotomy
65772 Corneal relaxing incision for correction of surgically induced astigmatism
65775 Corneal wedge resection for correction of surgically induced astigmatism
65778 Placement of amniotic membrane on the ocular surface; without sutures
65779 single layer, sutured
65780 Ocular surface reconstruction; amniotic membrane transplantation, multiple layers
65781 limbal stem allograft (eg, cadaveric or living donor)
65782 limbal conjunctival autograft (includes obtaining graft)

ANTERIOR CHAMBER

INCISION

65800 Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous
65810 with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection

65815 with removal of blood, with or without irrigation and/or air injection
65820 Goniotomy
(Do not report modifier -63 in conjunction with 65820)
(For use of ophthalmic endoscope with 65820, use 66990)
65850 Trabeculotomy ab externo
65855 Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)
65860 Severing adhesions of anterior segment, laser technique (separate procedure)
65865 Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); goniosynechiae
65870 anterior synechiae, except goniosynechiae
65875 posterior synechiae
(For use of ophthalmic endoscope with 65875, use 66990)
65880 corneovitreal adhesions

REMOVAL

65900 Removal of epithelial downgrowth, anterior chamber of eye
65920 Removal of implanted material, anterior segment of eye
(For use of ophthalmic endoscope with 65920, use 66990)
65930 Removal of blood clot, anterior segment of eye

INTRODUCTION

66020 Injection, anterior chamber of eye (separate procedure); air or liquid
66030 medication

ANTERIOR SCLERA

EXCISION

66130 Excision of lesion, sclera
66150 Fistulization of sclera for glaucoma; trephination with iridectomy
66155 thermocauterization with iridectomy
66160 sclerectomy with punch or scissors, with iridectomy
66170 trabeculectomy ab externo in absence of previous surgery
66172 trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)
66174 Transluminal dilation of aqueous outflow canal; without retention of device or stent
66175 with retention of device or stent

AQUEOUS SHUNT

66179 Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft
66180 with graft
66183 Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

66184 Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft
66185 with graft

REPAIR OR REVISION

66225 Repair of scleral staphyloma with graft
66250 Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure

IRIS, CILIARY BODY

INCISION

66500 Iridotomy by stab incision (separate procedure); except transfixion
66505 with transfixion as for iris bombe

EXCISION

66600 Iridectomy, with corneoscleral or corneal section; for removal of lesion
66605 with cyclectomy
66625 peripheral for glaucoma (separate procedure)
66630 sector for glaucoma (separate procedure)
66635 optical (separate procedure)

REPAIR

66680 Repair of iris, ciliary body (as for iridodialysis)
66682 Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture)

DESTRUCTION

66700 Ciliary body destruction; diathermy,
66710 cyclophotocoagulation, transscleral

66711 cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens
(Do not report 66711 in conjunction with 66990)
66720 cryotherapy
66740 cyclodialysis
66761 Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)
66762 Iridoplasty by photocoagulation (one or more sessions) (eg, for improvement of vision for widening of anterior chamber angle)
66770 Destruction of cyst or lesion iris or ciliary body (nonexcisional procedure)

LENS

INCISION

66820 Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)
66821 laser surgery (eg, YAG laser) (one or more stages)
66825 Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)

REMOVAL

Lateral canthotomy, iridectomy, iridotomy, anterior capsulotomy, posterior capsulotomy, the use of viscoelastic agents, enzymatic zonulysis, use of other pharmacologic agents, and subconjunctival or sub-tenon injections are included as part of the code for the extraction of lens.

66830 Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
66840 Removal of lens material; aspiration technique, one or more stages
66850 phacofragmentation technique (mechanical or ultrasonic,) (eg, phacoemulsification), with aspiration
66852 pars plana approach, with or without vitrectomy
66920 intracapsular
66930 intracapsular, for dislocated lens
66940 extracapsular (other than 66840, 66850, 66852)

INTRAOCULAR LENS PROCEDURES

66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation
66983 Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation
66985 Insertion of intraocular lens prosthesis (secondary implant) not associated with concurrent cataract removal
(For use of ophthalmic endoscope with 66985, use 66990)
66986 Exchange of intraocular lens
(For use of ophthalmic endoscope with 66986, use 66990)

OTHER PROCEDURES

66990 Use of ophthalmic endoscope
(List separately in addition to primary procedure)

(66990 may be used only with codes 65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041, 67042, 67043,67113)

66999 Unlisted procedure, anterior segment, eye

POSTERIOR SEGMENT

VITREOUS

67005 Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal

67010 subtotal removal with mechanical vitrectomy

67015 Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)

67025 Injection of vitreous substitute, pars plana or limbal approach, (fluid-gas exchange), with or without aspiration (separate procedure)

67027 Implantation of intravitreal drug delivery system (eg, Ganciclovir implant), includes concomitant removal of vitreous

67028 Intravitreal injection of a pharmacologic agent (separate procedure)

67030 Discission of vitreous strands (without removal), pars plana approach

67031 Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)

67036 Vitrectomy, mechanical, pars plana approach;

67039 with focal endolaser photocoagulation

67040 with endolaser panretinal photocoagulation

67041 with removal of preretinal cellular membrane (eg, macular pucker)

67042 with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)

67043 with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation

RETINA OR CHOROID

REPAIR

(If diathermy, cryotherapy and/or photocoagulation are combined, report under principal modality used)

67101 Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy

67105 photocoagulation

67107 Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation and drainage of subretinal fluid

67108 with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique

67110 by injection of air or other gas (eg, pneumatic retinopexy)
67113 Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens
67115 Release of encircling material (posterior segment)
67120 Removal of implanted material, posterior segment; extraocular
67121 intraocular

PROPHYLAXIS

Codes 67141, 67145, 67208-67220, 67227, 67228, 67229 include treatment at one or more sessions that may occur at different encounters. These codes should be reported once during a defined treatment period.

Repetitive services. The services listed below are often performed in multiple sessions or groups of sessions. The methods of reporting vary.

The following descriptors are intended to include all sessions in a defined treatment period.

67141 Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy
67145 photocoagulation (laser or xenon arc)

DESTRUCTION

67208 Destruction of localized lesion of retina (eg, macular edema, tumors) one or more sessions; cryotherapy, diathermy
67210 photocoagulation
67218 radiation by implantation of source (includes removal of source)
67220 Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), one or more sessions
67221 photodynamic therapy (includes intravenous infusion)
67225 photodynamic therapy, second eye, at single session
(List separately in addition to primary eye treatment)
(Use 67225 in conjunction with code 67221)
67227 Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; cryotherapy, diathermy
67228 Treatment of extensive or progressive retinopathy, one or more sessions; (eg, diabetic retinopathy), photocoagulation
67229 preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy
(For bilateral procedure, use modifier 50)

POSTERIOR SCLERAL

REPAIR

67250 Scleral reinforcement (separate procedure); without graft
67255 with graft

OTHER PROCEDURES

67299 Unlisted procedure, posterior segment

OCULAR ADNEXA

EXTRAOCULAR MUSCLES

(Use 67320, 67331, 67332, 67334 in conjunction with 67311-67318)

(Use 67335, 67340, in conjunction with 67311-67334)

(Use 67343 in conjunction with 67311-67340, when such procedures are performed other than on the affected muscle)

(For adjustable sutures, use 67335 in addition to codes 67311-67334 for primary procedure reflecting number of muscles operated on)

67311 Strabismus surgery, recession or resection procedure; one horizontal muscle
67312 two horizontal muscles
67314 one vertical muscle (excluding superior oblique)
67316 two or more vertical muscles (excluding superior oblique)
67318 Strabismus surgery, any procedure superior oblique muscle
67320 Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify)
(List separately in addition to primary procedure)
67331 Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles
(List separately in addition to primary procedure)
67332 Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy)
(List separately in addition to primary procedure)
67334 Strabismus surgery by posterior fixation suture technique, with or without muscle recession
(List separately in addition to primary procedure)
67335 Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s)
(List separately in addition to code for specific strabismus surgery)
67340 Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s)
(List separately in addition to primary procedure)
67343 Release of extensive scar tissue without detaching extraocular muscle (separate procedure)
67345 Chemodenervation of extraocular muscle
67346 Biopsy of extraocular muscle

OTHER PROCEDURES

67399 Unlisted procedure, extraocular muscle

ORBIT

EXPLORATION, EXCISION, DECOMPRESSION

67400 Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy
67405 with drainage only
67412 with removal of lesion
67413 with removal of foreign body
67414 with removal of bone for decompression
67415 Fine needle aspiration of orbital contents
67420 Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion
67430 with removal of foreign body
67440 with drainage
67445 with removal of bone for decompression
67450 for exploration, with or without biopsy

OTHER PROCEDURES

67500 Retrobulbar injection; medication (separate procedure, does not include supply of medication)
67505 alcohol
67515 Injection of medication or other substance into Tenon's capsule
67550 Orbital implant (implant outside muscle cone); insertion
67560 removal or revision
67570 Optic nerve decompression (eg, incision or fenestration of optic nerve sheath)
67599 Unlisted procedure, orbit

EYELIDS

INCISION

67700 Blepharotomy, drainage of abscess, eyelid
67710 Severing of tarsorrhaphy
67715 Canthotomy (separate procedure)

EXCISION, DESTRUCTION

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

67800 Excision of chalazion; single
67801 multiple, same lid

67805 multiple, different lids
67808 under general anesthesia and/or requiring hospitalization, single or multiple
67810 Incisional biopsy of eyelid skin including lid margin
67820 Correction of trichiasis; epilation, by forceps only
67825 epilation by other than forceps (eg, by electrosurgery, cryotherapy, laser surgery)
67830 incision of lid margin
67835 incision of lid margin, with free mucous membrane graft
67840 Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure
67850 Destruction of lesion of lid margin (up to 1 cm)

TARSORRHAPHY

67875 Temporary closure of eyelids by suture (eg, Frost suture)
67880 Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;
67882 with transposition of tarsal plate

REPAIR (BROW PTOSIS, BLEPHAROPTOSIS, LID RETRACTION, ECTROPION, ENTROPION)

67900 Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901 Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902 frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903 (tarso) levator resection or advancement, internal approach
67904 (tarso) levator resection or advancement, external approach
67906 superior rectus technique with fascial sling (includes obtaining fascia)
67908 conjunctivo-tarso-Muller’s muscle-levator resection (Fasanella-Servat type)
67909 Reduction of overcorrection of ptosis
67911 Correction of lid retraction
67912 Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)
67914 Repair of ectropion; suture
67915 thermocauterization
67916 excision tarsal wedge
67917 extensive (eg, tarsal strip operations)
67921 Repair of entropion; suture
67922 thermocauterization
67923 excision tarsal wedge
67924 extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)

RECONSTRUCTION

Codes for blepharoplasty involve more than skin (ie, involving lid margin, tarsus, and/or palpebral conjunctiva)

67930 Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva, direct closure; partial thickness
67935 full thickness
67938 Removal of embedded foreign body, eyelid

67950 Canthoplasty (reconstruction of canthus)
67961 Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one fourth of lid margin
67966 over one fourth of lid margin
67971 Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, one stage or first stage
67973 total eyelid, lower, one stage or first stage
67974 total eyelid, upper, one stage or first stage
67975 second stage

OTHER PROCEDURES

67999 Unlisted procedure, eyelids

CONJUNCTIVA

INCISION AND DRAINAGE

68020 Incision of conjunctiva, drainage of cyst
68040 Expression of conjunctival follicles (eg, for trachoma)

EXCISION AND/OR DESTRUCTION

68100 Biopsy of conjunctiva
68110 Excision of lesion, conjunctiva; up to 1 cm
68115 over 1 cm
68130 with adjacent sclera
68135 Destruction of lesion, conjunctiva

INJECTION

68200 Subconjunctival injection

CONJUNCTIVOPLASTY

68320 Conjunctivoplasty; with conjunctival graft or extensive rearrangement
68325 with buccal mucous membrane graft (includes obtaining graft)
68326 Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement
68328 with buccal mucous membrane graft (includes obtaining graft)
68330 Repair of symblepharon; conjunctivoplasty, without graft
68335 with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)
68340 division of symblepharon with or without insertion of conformer or contact lens

OTHER PROCEDURES

68360 Conjunctival flap; bridge or partial (separate procedure)

68362 total (such as Gunderson thin flap or purse string flap)
68399 Unlisted procedure, conjunctiva

LACRIMAL SYSTEM

INCISION

68400 Incision, drainage of lacrimal gland
68420 Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy)
68440 Snip incision of lacrimal punctum

EXCISION

68500 Excision of lacrimal gland (dacryoadenectomy), except for tumor; total
68505 partial
68510 Biopsy of lacrimal gland
68520 Excision of lacrimal sac (dacryocystectomy)
68525 Biopsy of lacrimal sac
68530 Removal of foreign body or dacryolith, lacrimal passages
68540 Excision of lacrimal gland tumor; frontal approach
68550 involving osteotomy

REPAIR

68700 Plastic repair of canaliculi
68705 Correction of everted punctum, cautery
68720 Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)
68745 Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube
68750 with insertion of tube or stent
68760 Closure of lacrimal punctum; by thermocauterization, ligation, or laser surgery
68761 by plug, each
68770 Closure of lacrimal fistula (separate procedure)

PROBING AND/OR RELATED PROCEDURES

(For codes 68801 – 68816, for bilateral procedures, use modifier -50)

68801 Dilation of lacrimal punctum, with or without irrigation
68810 Probing of nasolacrimal duct, with or without irrigation;
68811 requiring general anesthesia
68815 with insertion of tube or stent
See also 92018
68816 Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation
(Do not report 68816 in conjunction with 68810, 68811, 68815)
68840 Probing of lacrimal canaliculi, with or without irrigation
68850 Injection of contrast medium for dacryocystography

OTHER PROCEDURES

68899 Unlisted procedure, lacrimal system

AUDITORY SYSTEM

EXTERNAL EAR

INCISION

69000 Drainage external ear, abscess or hematoma; simple
69005 complicated
69020 Drainage external auditory canal, abscess

EXCISION

69100 Biopsy external ear
69105 Biopsy external auditory canal
69110 Excision external ear; partial, simple repair
69120 complete amputation
69140 Excision exostosis(es), external auditory canal
69145 Excision soft tissue lesion, external auditory canal
69150 Radical excision external auditory canal lesion; without neck dissection
69155 with neck dissection

REMOVAL

(For codes 69220, 69222, for bilateral procedures use modifier -50)

69200 Removal foreign body from external auditory canal; without general anesthesia
69205 with general anesthesia
69210 Removal impacted cerumen requiring instrumentation (report one unit for unilateral **OR** bilateral procedure)
69220 Debridement, mastoidectomy cavity, simple (eg, routine cleaning)
69222 Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)

REPAIR

69300 Otoplasty, protruding ear, with or without size reduction
(For bilateral procedure, report 69300 with modifier 50)
69310 Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection), separate procedure
69320 Reconstruction of external auditory canal for congenital atresia, single stage

OTHER PROCEDURES

69399 Unlisted procedure, external ear

MIDDLE EAR

INCISION

(For codes 69433, 69436, for bilateral procedures use modifier -50)

69420 Myringotomy including aspiration and/or eustachian tube inflation
69421 Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia
69424 Ventilating tube removal requiring general anesthesia
69433 Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia
69436 Tympanostomy (requiring insertion of ventilating tube), general anesthesia
69440 Middle ear exploration through postauricular or ear canal incision
69450 Tympanolysis, transcanal

EXCISION

69501 Transmastoid antrotomy (simple mastoidectomy)
69502 Mastoidectomy; complete
69505 modified radical
69511 radical
69530 Petrous apicectomy including radical mastoidectomy
69535 Resection temporal bone, external approach
69540 Excision aural polyp
69550 Excision aural glomus tumor; transcanal
69552 transmastoid
69554 extended (extratemporal)

REPAIR

69601 Revision mastoidectomy; resulting in complete mastoidectomy
69602 resulting in modified radical mastoidectomy
69603 resulting in radical mastoidectomy
69604 resulting in tympanoplasty
69610 Tympanic membrane repair, with or without site preparation or perforation for closure, with or without patch
69620 Myringoplasty (surgery confined to drumhead and donor area)
69631 Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
69632 with ossicular chain reconstruction, (eg, postfenestration)
69633 with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, (PORP), total ossicular replacement prosthesis, (TORP))
69635 Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction
69636 with ossicular chain reconstruction

69637 with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, (PORP), total ossicular replacement prosthesis, (TORP))
69641 Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction
69642 with ossicular chain reconstruction
69643 with intact or reconstructed wall, without ossicular chain reconstruction
69644 with intact or reconstructed canal wall, with ossicular chain reconstruction
69645 radical or complete, without ossicular chain reconstruction
69646 radical or complete, with ossicular chain reconstruction
69650 Stapes mobilization
69660 Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;
69661 with footplate drill out
69662 Revision of stapedectomy or stapedotomy
69666 Repair oval window fistula
69667 Repair round window fistula
69670 Mastoid obliteration (separate procedure)
69676 Tympanic neurectomy
(For bilateral procedure, use modifier -50)

OTHER PROCEDURES

69700 Closure postauricular fistula, mastoid (separate procedure)
69705 Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral
69706 bilateral
69710 Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone
(Replacement procedure includes removal of old device)
69711 Removal or repair of electromagnetic bone conduction hearing device in temporal bone
69714 Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715 with mastoidectomy
69717 Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718 with mastoidectomy
69720 Decompression facial nerve, intratemporal; lateral to geniculate ganglion
69725 including medial to geniculate ganglion
69740 Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion
69745 including medial to geniculate ganglion
69799 Unlisted procedure, middle ear

INNER EAR

INCISION AND/OR DESTRUCTION

69801 Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal
(Do not report 69801 more than once per day)
(Do not report 69801 in conjunction with 69420, 69421, 69433, 69436 when performed on the same ear)
69805 Endolymphatic sac operation; without shunt
69806 with shunt

EXCISION

69905 Labyrinthectomy; transcanal
69910 with mastoidectomy
69915 Vestibular nerve section, translabyrinthine approach

INTRODUCTION

69930 Cochlear device implantation, with or without mastoidectomy

OTHER PROCEDURES

69949 Unlisted procedure, inner ear

TEMPORAL BONE, MIDDLE FOSSA APPROACH

69950 Vestibular nerve section, transcranial approach
69955 Total facial nerve decompression and/or repair (may include graft)
69960 Decompression internal auditory canal
69970 Removal of tumor, temporal bone

OTHER PROCEDURES

69979 Unlisted procedure, temporal bone, middle fossa approach