NEW YORK STATE
MEDICAID PROGRAM

PHYSICIAN – PROCEDURE CODES

SECTION 5 - SURGERY

Table of Contents

ANESTHESIA SECTION

For moderate conscious sedation, see codes 99143 – 99150, in the Medicine section.

This is the only specialty that will continue to be concerned with units for claim submission purposes. The maximum conversion factor is $10.00.

Enter Total Anesthesia Value (total units) for each procedure in the units column of the MMIS Claim Form.

GENERAL INFORMATION AND RULES

1. The total values for anesthesia services include pre- and post-operative visits, the administration of the anesthetic and the administration of fluids and/or blood incident to the anesthesia or surgery.
2. Calculated values for anesthesia services are to be used only when the anesthesia is administered by a physician who remains in constant attendance during the procedure for the sole purpose of rendering such anesthesia service.

   When more than one anesthesiologist is billing due to attending in shifts only the first anesthesiologist is allowed to bill the Basic Value, all others should bill the anesthesia time only, do not add the Basic Value in addition to time when billing the second, third, shift etc. Anesthesiologists should bill on paper documenting their time in attendance.
3. When hypothermia and/or a pump oxygenator are employed in conjunction with an anesthetic, see procedure code(s) 99116, 99190, 99191, 99192. Do not report the Anesthesia Basic Value in addition to time when billing code(s) 99116, 99190, 99191, 99192 separately.

   To bill for the anesthesia time, report the appropriate surgery procedure code with modifier -AA. The total time billed should represent the anesthesia time only. Do not include the Anesthesia Basic Value in the calculation of the total anesthesia value.
4. If the general or regional anesthetic is administered by the attending surgeon, the fee will be fifty percent of the ordinarily calculated anesthesia value (see below). Such procedures shall be identified by adding the modifier -47 to the MMIS surgical procedure code. This does not apply to local anesthesia (see Rule #8).
5. In procedures where no value is listed, the basic portion of the calculated value will be the same as listed for comparable procedures. For claiming purposes, the closest comparable surgical procedure code will be used for such procedures.
6. Necessary drugs and materials provided by the anesthesiologist may be charged for separately.
7. Where unusual detention with the patient is essential for the safety and welfare of such patient, the necessary time will be valued on the same basis as indicated below for anesthesia time.
8. No fee will be allowed for local infiltration or digital block anesthesia administered by the operating surgeon.

9. Anesthesia services not connected with surgery will be found in other sections of this fee schedule.

10. ALL anesthesia services must be identified by adding the modifier -23, -47, or -AA, to the same MMIS code number as the related surgical procedure.

11. Anesthesia Report (or Operative Record) must document total time spent with the patient and include starting time, completion time and an explanation of any unusual occurrence which prolonged anesthesia time.

12. The following MMIS MODIFIERS are commonly used in anesthesia:

    -23 Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier -23 to the procedure code of the basic service. (Reimbursement will not exceed $30 plus time for the procedure.)

    -47 Anesthesia By Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding the modifier -47 to the basic service. (This does not include local anesthesia.) (Reimbursement will not exceed 50% of the basic value plus time for the procedure.)

    -AA Anesthesia Services Preformed Personally By Anesthesiologist: All anesthesia services not reported with modifiers –23 or -47 will be identified by adding the modifier -AA to the procedure number of the surgical procedure. (Reimbursement will not exceed the basic value plus time for the procedure.)

    For Anesthesia Complicated By Total Body Hypothermia and/or PUMP Oxygenator, see procedure code(s) 99116, 99190, 99191, 99192. Do not report these codes with an anesthesia modifier. See also Anesthesia Section, Rule #3.

CALCULATION OF TOTAL ANESTHESIA VALUES

Calculation of total anesthesia value is determined by adding the listed basic value and time units. To bill for the anesthesia time report the appropriate surgery procedure code with modifier –AA. When billing for anesthesia complicated by total body hypothermia and/or pump oxygenator, see procedure code(s) 99116, 99190, 99191, 99192. Do not report the anesthesia basic value in addition to time when billing code(s) 99116, 99190, 99191, 99192 separately. The total time billed on the service specific code should represent the anesthesia time only.

A basic value is listed for most procedures. This includes the value of all anesthesia services except the value of the actual time spent administering the anesthesia or in unusual detention with the patient (see also Anesthesia Rule #7).

The time units are computed by allowing one unit for each 15 minutes of anesthesia time. After the total anesthesia time is calculated, the resulting number of units should be rounded to the next whole number. Anesthesia time starts with the beginning of the administration of the anesthetic agents and ends when the anesthesiologist is no longer in personal attendance (when the patient may be safely placed under customary post-operative supervision).

For example, in a procedure with a basic value of 5 units requiring two hours and forty-five minutes of an anesthesiologist's time, the time units total 11, and are added to the basic value of 5, producing a total anesthesia value of 16 units for this anesthesia service.

Basic Value + Time Units = TOTAL ANESTHESIA VALUE

CALCULATION OF ANESTHESIA VALUES FOR MULTIPLE/BILATERAL SURGICAL PROCEDURES

When multiple or bilateral surgical procedures, which add time and complexity to patient care, are performed at the same operative session, the total anesthesia value should be calculated by taking 100% of the basic unit value assigned to the major surgical procedure plus the total time worked (1 hour 15 minutes, 2 hours 45 minutes, etc).

The surgical procedure assigned the highest reimbursable fee may be considered the major procedure performed. Use the MMIS procedure code for the major procedure performed and the appropriate modifier (-23, -47, or -AA) when billing according to this instruction. (NOTE: Attach copy of Anesthesia Report to Operative Record which must verify total time spent with the patient.)

SURGERY SECTION

GENERAL INFORMATION AND RULES

1. **FEES:** The fees are listed in the Physician Surgery Fee Schedule, available at http://www.emedny.org/ProviderManuals/Physician/index.html
   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)

5. 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)

6. **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.

7. **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.

8. **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.

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

10. **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 SERVICES FOR ASSIST AT SURGERY:** When a physician requests a nurse practitioner or a physician's 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.

11. **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 immunglobulin) 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.

12. **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.

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, 58293, 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. **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/

-47 Anesthesia By Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding the modifier -47 to the basic service. (This does not include local anesthesia.) (Reimbursement will not exceed 50% of the basic value plus time for the procedure.)

-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 20000-69999 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.)

-AS Physician Assistant or Nurse Practitioner Services for Assist at Surgery: When the physician requests that a Physician Assistant or Nurse Practitioner 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).

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

-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; without imaging guidance
10022 with imaging guidance
(For radiological supervision and interpretation, see 76942, 77002, 77012, 77021)

(For percutaneous needle biopsy, other than fine needle aspiration, see 20206 for muscle, 32400 for pleura, 32405 for lung or mediastinum, 42400 for salivary gland, 47000, 47001 for liver, 48102 for pancreas, 49180 for abdominal or retroperitoneal mass, 60100 for thyroid, 62269 for spinal cord)

INTERGUMENTARY SYSTEM

SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES

INCISION AND DRAINAGE

(For excision, see 11400, et seq)

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

(For excision of pilonidal cyst, see 11770-11772)

10120 Incision and removal of foreign body, subcutaneous tissues; simple
10121 complicated

(To report wound exploration due to penetrating trauma without laparotomy or thoracotomy, see 20100-20103, as appropriate)
(To report debridement associated with open fracture(s) and/or dislocation(s), use 11010-11012, as appropriate)

10140 Incision and drainage of hematoma, seroma or fluid collection
(If imaging guidance is performed, see 76942, 77012, 77021)

10160 Puncture aspiration of abscess, hematoma, bulla or cyst
(If imaging guidance is performed, see 76942, 77012, 77021)

10180 Incision and drainage, complex, postoperative wound infection

(For secondary closure of surgical wound, see 12020, 12021, 13160)

EXCISION – DEBRIDEMENT

(For dermabrasions, see 15780-15783)
(For nail debridement, see 11720-11721)
(For burn(s), see 16000-16035)

11000 Debridement of extensive eczematous or infected skin; up to 10% of body surface

(For abdominal wall or genitalia debridement for necrotizing soft tissue infection, see 11004-11006)

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)

(When insertion of mesh is used for closure, use 49568)
(If orchiectomy is performed, use 54520)
(If testicular transplantation is performed, use 54680)

11010 Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues
11011 skin, subcutaneous tissue, muscle fascia, and muscle
11012 skin, subcutaneous tissue, muscle fascia, muscle, and bone
11040 Debridement; skin, partial thickness
11041 skin, full thickness
11042 skin, and subcutaneous tissue
11043 skin, subcutaneous tissue, and muscle
11044 skin, subcutaneous tissue, muscle, and bone

PARING OR CUTTING

(To report destruction, see 17000-17004)

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, 11100, 11101) indicates that the procedure to obtain tissue for pathologic examination was performed independently, or was unrelated or distinct from other procedures/services provided at that time. Such biopsies are not considered components of other procedures when performed on different lesions or different sites on the same date, and are to be reported separately.

(For biopsy of conjunctiva, use 68100; eyelid, use 67810)

11100 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion
11101 each separate/additional lesion
(List separately in addition to primary procedure)
(Use 11101 in conjunction with 11100)

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 judgement. 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 benign lesions requiring more than simple closure, ie, requiring intermediate or complex closure, report 11400-11466 in addition to appropriate intermediate (12031-12057) or complex closure (13100-13153) codes. For reconstructive closure, see 15002-15261, 15570-15770. For definition of intermediate or complex closure, see Integumentary System, Repair (Closure).

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

(For eyelids involving more than skin, see also 67800 et seq)

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)

(When skin graft or flap is used for closure, use appropriate procedure code in addition)

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

(For eyelids involving more than skin, see also 67800 et seq)

NAILS

(For drainage of paronychia or onychia, see 10060, 10061)

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;
11752 with amputation of tuft of distal phalanx

(For skin graft, if used, see 15050)

11755 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (seperate 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)

(For veins, see 36470, 36471)
(For intralesional chemotherapy administration, see 96405, 96406)

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 **(Report required)**
(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 **(Report required)**
11951 1.1 to 5 cc **(Report required)**
11952 5.1 to 10 cc **(Report required)**
11954 over 10 cc **(Report required)**
11960 Insertion of tissue expander(s) for other than breast, including subsequent expansion

(For breast reconstruction with tissue expander(s), use 19357)

11970 Replacement of tissue expander with permanent prosthesis
11971 Removal of tissue expander(s) without insertion of prosthesis
11975 Insertion, implantable contraceptive capsules
11976 Removal, implantable contraceptive capsules
11977 Removal with reinsertion, 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 imtermediate 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 11040-11044)

(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 11040-11044.)

(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

(Sum of length of repairs for each group of anatomic sites)

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

(For extensive or complicated secondary wound closure, see 13160)

REPAIR-INTERMEDIATE

(Sum of length of repairs for each group of anatomic sites.)

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

Reconstructive procedures, complicated wound closure.
Sum of length of repairs for each group of anatomic sites.
(For full thickness repair of lip or eyelid, see respective anatomical subsections.)

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)

13150 Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less
(See also 40650-40654, 67961-67975)

13151 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

(For packing or simple secondary wound closure, see 12020)

ADJACENT TISSUE TRANSFER OR REARRANGEMENT

For full thickness repair of lip or eyelid, see respective anatomical subsections.

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

(For eyelid, full thickness, see 67961 et seq)

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 AND SKIN SUBSTITUTES

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.

Use 15002-15005 for initial wound recipient site preparation.

Use 15100-15261 for autogenous skin grafts. For autogenous tissue-cultured epidermal grafts, use 15150-15157. For harvesting of autologous keratinocytes and dermal tissue for tissue-cultured skin grafts, use 15040. Procedures are coded by recipient site. Use 15170-15176 for acellular dermal replacement.

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. Codes 15100-15431 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 fixaton 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.

(For microvascular flaps, see 15756-15758)

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, 15330-15336]. List the graft or replacement separately by its procedure number when the graft, immediate or delayed, is applied)

(For excision of benign lesions, see 11400-11471)
(For excision of malignant lesions, see 11600-11646)
(For excision to prepare or create recipient site with dressings or materials not listed in 15040-15431, use 15002-15005 only)
(For excision with immediate allograft skin placement, use 15002-15005 in conjunction with 15300-15336 and 15360-15366)
(For excision with immediate xenogeneic dermis placement, use 15002-15005 in conjunction with 15400-15421)
(For excision with immediate skin grafting, use 15002-15005 in conjunction with 15050-15261)

GRAFTS

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)

(For eyelids, see also 67961 et seq)

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 epidermal 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 one percent 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 epidermal 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 one percent of body area of infants and children, or part thereof
(List separately in addition to primary procedure)
(Use 15157 in conjunction with 15156)

ACELLULAR DERMAL REPLACEMENT

15170 Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

15171 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 15171 in conjunction with 15170)

15175 Acellular dermal replacement, 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

15176 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 15176 in conjunction with 15175)

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

(For finger tip graft, use 15050)
(For repair of syndactyly, fingers, see 26560-26562)

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)

(For eyelids, see also 67961 et seq)
(Repair of donor site requiring skin graft or local flaps, to be added as additional separate procedure)

ALLOGRAFT/TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE

Application of a non-autologous human skin graft (ie, homograft) from a donor to a part of the recipient's body to resurface an area damaged by burns, traumatic injury, soft tissue infection and/or tissue necrosis or surgery.

15300 Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children
15301 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 15301 in conjunction with 15300)

15320 Allograft skin for temporary wound closure, 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
15321 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 15321 in conjunction with 15320)

15330 Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

15331 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 15331 in conjunction with 15330)

15335 Acellular dermal allograft, 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

15336 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 15336 in conjunction with 15335)

15340 Tissue cultured allogeneic skin substitute; first 25 sq cm or less

15341 each additional 25 sq cm, or part thereof
(Use 15341 in conjunction with 15340)
(Do not report 15340, 15341 in conjunction with 11040-11042, 15002-15005)

15360 Tissue cultured allogeneic dermal substitute; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

15361 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 15361 in conjunction with 15360)

15365 Tissue cultured allogeneic dermal substitute, 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

15366 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 15366 in conjunction with 15365)

XENOGRAFT

Application of a non-human skin graft or biologic wound dressing (eg, porcine tissue or pigskin) to a part of the recipient's body following debridement of the burn wound or area of traumatic injury, soft tissue infection and/or tissue necrosis, or surgery.

15400 Xenograft, skin (dermal), for temporary wound closure; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children

15401 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 15401 in conjunction with 15400)

15420 Xenograft skin (dermal), for temporary wound closure, 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

15421 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 15421 in conjunction with 15420)

15430 Acellular xenograft implant; first 100 sq cm or less, or one percent of body area of infants and children

15431 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 15431 in conjunction with 15430)

(Do not report 15430, 15431 in conjunction with 11040-11042, 15002-15005)

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.

(For microvascular flaps, see 15756-15758)
(For flaps without inclusion of a vascular pedicle, see 15570-15576)
(For adjacent tissue transfer flaps, see 14000-14302)

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

(For eyelids, nose, ears or lips, see also specific anatomic section)
(For revision, defatting or rearranging of transferred pedicle flap or skin graft, see 13100-14302)

15731 Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)

(Procedures 15732-15738 are described by donor site of the muscle, myocutaneous, or fasciocutaneous flap)

15732 Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, massetermuscle, 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
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 **(Report required)**
15776 more than 15 punch grafts **(Report required)**

(For strip transplant, use 15220)

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) **(Report required)**
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 repair of brow ptosis, use 67900)

15825 neck with platysmal tightening (platysmal flap, P-flap)
15826 glabellar frown lines
15828 cheek, chin, and neck
15829 superficial musculoaponeurotic system (SMAS) flap **(Report required)**

(For bilateral rhytidectomy, add modifier 50)

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)
(To report abdominoplasty with panniculectomy, use 15830 in conjunction with 15847. to report other abdominoplasty, use 17999)

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

(For intravenous fluorescein examination of blood flow in graft or flap, use 15860)
(For nerve transfers, decompression, or repair, see 64831-64876, 64905, 64907, 69720, 69725, 69740, 69745, 69955)

15847 Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) **(Report required)**
(List separately in addition to primary procedure)
(Use 15847 in conjunction with 15830)

(For abdominal wall hernia repair, see 49491-49587)
(To report other abdominoplasty, use 17999)

15850 Removal of sutures under anesthesia (other than local), same surgeon **(See Rule 4) (Report required)**
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 **(Report required)**
15877 trunk **(Report required)**
15878 upper extremity **(Report required)**
15879 lower extremity **(Report required)**

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

(For repair of defect using muscle or myocutaneous flap, use code(s) 15734 and/or 15738 in addition to 15936, 15937)
(For repair of defect using split skin graft, use codes 15100 and/or 15101 in addition to 15936, 15937)

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

(For repair of defect using muscle or myocutaneous flap, use code(s) 15734 and/or 15738 in addition to 15946)
(For repair of defect using split skin graft, use codes 15100 and/or 15101 in addition to 15946)

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

(For repair of defect using muscle or myocutaneous flap, use code(s) 15734 and/or 15738 in addition to 15956, 15958)
(For repair of defect using split skin graft, use codes 15100 and/or 15101 in addition to 15956, 15958)

15999 Unlisted procedure, excision pressure ulcer

(For free skin graft to close ulcer or donor site, see 15002 et seq)

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 15100-15431.

List percentage of body surface involved and depth of burn.

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

For the application of skin grafts or skin substitutes, see 15100-15650.

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)

(For debridement, curettement of burn wound, see 16020-16030)

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 electrocautery, electrodesiccation, 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.

(For destruction of lesion(s) in specific anatomic sites; see 40820, 46900-46917, 46924, 54050-54057, 54065, 56501, 56515, 57061, 57065, 67850, 68135)
(For paring or cutting of benign hyperkeratonic lesions (eg, corns or calluses), see 11055 – 11057)
(For sharp removal or electrosurgical destruction of skin tags and fibrocutaneous tags, see 11200, 11201)
(For cryotherapy of acne, use 17340)

(For initiation or follow-up care of topical chemotherapy (eg, 5-FU or similar agents), see appropriate office visits)
(For shaving of epidermal or dermal lesions, see 11300-11313)

DESTRUCTION, BENIGN OR PREMALIGNANT LESIONS

17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); first lesion **(Report required)**

17003 second through 14 lesions, each **(Report required)**
(List separately in addition to code for first lesion)
(Use 17003 in conjunction with 17000)

(For destruction of common or plantar warts, see 17110, 17111)

17004 15 or more lesions **(Report required)**
(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 (proud flesh, sinus or fistula)
(17250 is not to be used with excision/removal codes for the same lesions)

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 **(Report required)**

17266 lesion diameter over 4.0 cm **(Report required)**

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 **(Report required)**
17284 lesion diameter 3.1 to 4.0 cm **(Report required)**
17286 lesion diameter over 4.0 cm **(Report required)**

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. If a biopsy of a suspected skin cancer is performed on the same day as Mohs surgery because there was no prior pathology confirmation of a diagnosis, then report diagnostic skin biopsy (11100, 11101).

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 **(Report required)**
(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 Electrolusis 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)

(If imaging guidance is performed, see 76942, 77021, 77031, 77032)

19020 Mastotomy with exploration or drainage of abscess, deep
19030 Injection procedure only for mammary ductogram or galactogram
(For radiological supervision and interpretation, see 77053, 77054)

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 19260-19272 are not restricted to breast tumors and are used to report resections of chest wall tumors originating from any chest wall component.

(For excision of lung or pleura, see 32310 et seq.)

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

(For fine needle aspiration, use 10021)
(For image guided breast biopsy, see 19102, 19103, 10022)

19101 open, incisional

19102 percutaneous, needle code, using imaging guidance

(For placement of percutaneous localization clip, use 19295)

19103 percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

(For imaging guidance performed in conjunction with 19102, 19103, see 76942, 77012, 77021, 77031, 77032)
(For placement of percutaneous localization clip, use 19295)

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

(For adjacent lesions treated with one cryoprobe insertion, report once)

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 19260, 19271, 19272 in conjunction with 32100, 32422, 32503, 32504, 32551)

19260 Excision of chest wall tumor including ribs

19271 Excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy
19272 with mediastinal lymphadenectomy

INTRODUCTION

19290 Preoperative placement of needle localization wire, breast;
19291 each additional lesion
(List separately in addition to primary procedure)
(Use 19291 in conjunction with code 19290)
(For radiological supervision and interpretation, see 76942, 77031, 77032)

19295 Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration
(List separately in addition to primary procedure)
(Use 19295 in conjunction with code 19102, 19103)

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 **(Report required)**
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 **(Report required)**

MASTECTOMY PROCEDURES

(For immediate or delayed insertion of implant for codes 19303, 19304, 19305, 19306, 19307, see 19340, 19342)

19300 Mastectomy for gynecomastia
19301 Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);
19302 with axillary lymphadenectomy

(For placement of radiotherapy afterloading balloon/brachytherapy catheters, see 19296-19298)

19303 Mastectomy, simple, complete

(For gynecomastia, use 19300)

19304 Mastectomy, subcutaneous
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 Reduction mammaplasty (unilateral)
19324 Mammaplasty, augmentation; without prosthetic implant
19325 with prosthetic implant

(For flap or graft, use also appropriate number)

19328 Removal of intact mammary implant
19330 Removal of implant material
19340 Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342 Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

(For physician supply of implant, use 99070)
(For preparation of custom breast implant, use 19396)

19350 Nipple/areola reconstruction
19355 Correction of inverted nipples
19357 Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361 Breast reconstruction with latissimus dorsi flap, without prosthetic implant

(For insertion of prosthesis, use also 19340)

19364 Breast reconstruction with free flap
(19364 includes harvesting of the flap, microvascular transfer, closure of the donor site, and inset shaping the flap into a breast)

19366 Breast reconstruction with other technique

(For insertion of prosthesis, use also 19340 or 19342)

19367 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
19368 with microvascular anastomosis (supercharging)
19369 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
19370 Open periprosthetic capsulotomy, breast
19371 Periprosthetic capsulectomy, breast
19380 Revision of reconstructed breast
19396 Preparation of moulage for custom breast implant **(Report required)**

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

20000 Incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial
20005 deep or complicated

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

(For aspiration of bone marrow, use 38220)

20200 Biopsy, muscle; superficial
20205 deep
20206 Biopsy, muscle, percutaneous needle

(If imaging guidance is performed, see 76942, 77012, 77021)
(For fine needle aspiration, use 10021, 10022)
(For excision of muscle tumor, deep, see specific anatomic section)

20220 Biopsy, bone, trocar or needle; superficial (eg, ilium, sternum, spinous process, ribs)
20225 deep (eg, vertebral body, femur)
(For radiological supervision and interpretation, see 77002, 77012, 77021)

(For bone marrow biopsy, use 38221)

20240 Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur)
20245 deep (eg, humerus, ischium, femur)
20250 Biopsy, vertebral body, open; thoracic
20251 lumbar or cervical

(For sequestrectomy, osteomyelitis or drainage of bone abscess, see. specific anatomic section)

INTRODUCTION OR REMOVAL

(For injection procedure for arthrography, see specific anatomic section)

20500 Injection of sinus tract; therapeutic (separate procedure)
20501 diagnostic (sinogram)
(For radiological supervision and interpretation, see 76080)

20520 Removal of foreign body in muscle, or tendon sheath, simple
20525 deep or complicated
20526 Injection, therapeutic (eg, local anesthetic; corticosteroid), carpal tunnel
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)

(If imaging guidance is performed, see 76942, 77002, 77021)

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)

(For placement of devices into the breast for interstitial radioelement application, see 19296-19298)
(For placement of needles, catheters, or devices into muscle or soft tissue of the head and neck, for interstitial radioelement application, use 41019)
(For placement of needles or catheters for interstitial radioelement application into prostate, use 55875)
(For placement of needles or catheters into the pelvic organs or genitalia [except prostate] for interstitial radioelement application, use 55920)
(For imaging guidance, see 76942, 77002, 77012, 77021)

20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)
20605 intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)

20610 major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

(If imaging guidance is performed, see 76942, 77002, 77012, 77021)

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), requiring general anesthesia
20665 Removal of tongs or halo applied by another physician
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.
(For spinal surgery bone graft(s) see codes 20930-20938)

20900 Bone graft, any donor area; minor or small (eg, dowel or button)
20902 major or large
20910 Cartilage graft; costochondral
20912 nasal septum

(For ear cartilage, use 21235)

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)
20926 Tissue grafts, other (eg, paratenon, fat, dermis)

(Codes 20930-20938 are reported in addition to codes for the definitive procedure(s).
(Report only one bone graft code per operative session.)

20930 Allograft for spine surgery only; morselized
(List separately in addition to primary procedure)
(Use 20930 in conjunction with 22319, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812)

20931 structural
(List separately in addition to primary procedure)
(Use 20931 in conjunction with 22319, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812)

20936 Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision
(List separately in addition to primary procedure)
(Use 20936 in conjunction with 22319, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812)

20937 morselized (through separate skin or fascial incision)
(List separately in addition to primary procedure)
(Use 20937 in conjunction with 22319, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812)

20938 structural, bicortical or tricortical (through separate skin or fascial incision)
(List separately in addition to code for primary procedure)
(Use 20938 in conjunction with 22319, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812)

(For needle aspiration of bone marrow for the purpose of bone grafting, use 38220)

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 **(Report required)**
20972 metatarsal **(Report required)**
20973 great toe with web space **(Report required)**

(For great toe, wrap-around procedure, use 26551)

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, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance **(Report required)**
(Do not report 20982 in conjunction with 77013)

20999 Unlisted procedure, musculoskeletal system, general

HEAD

Skull, facial bones and temporomandibular joint.

INCISION

(For drainage of superficial abscess and hematoma, see 20000)
(For removal of embedded foreign body from dentoalveolar structure, see 41805, 41806)

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, malignant neoplasm), 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
(For enucleation and/or curettage of benign cysts or tumors of mandible not requiring osteotomy, use 21040)

(For excision of benign tumor or cyst of mandible requiring osteotomy, see 21046-21047)

21044 Excision of malignant tumor of mandible;
21045 radical resection

(For bone graft, see 21215)

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) **(Report required)**

(For TMJ manipulation without an anesthesia service [ie, general or monitored anesthesia care], see 97140, 98925-98929, 98943)
(For closed treatment of temporomandibular dislocation, see 21480, 21485)

HEAD PROSTHESIS

(For application or removal of caliper or tongs, see 20660,20665)

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 **(Report required)**
21077 orbital prosthesis **(Report required)**
21079 interim obturator prosthesis **(Report required)**
21080 definitive obturator prosthesis **(Report required)**
21081 mandibular resection prosthesis **(Report required)**

21082 palatal augmentation prosthesis **(Report required)**
21083 palatal lift prosthesis **(Report required)**
21084 speech aid prosthesis **(Report required)**
21085 oral surgical splint
21086 auricular prosthesis **(Report required)**
21087 nasal prosthesis **(Report required)**
21088 facial prosthesis
21089 Unlisted maxillofacial prosthetic procedure

INTRODUCTION OR REMOVAL

21100 Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure) **(Report required)**
21110 Application of interdental fixation device for conditions other than fracture or dislocation, includes removal

(For removal of interdental fixation by another physician, see 20670-20680)

21116 Injection procedure for temporomandibular joint arthrography

(For radiological supervision and interpretation, use 70332. Do not report 77002 in conjunction with 70332)

REPAIR, REVISION, AND/OR RECONSTRUCTION

(For cranioplasty, see 21179, 21180 and 62116, 62120, 62140-62147)

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) **(Report required)**
21125 Augmentation, mandibular body or angle; prosthetic material
21127 with bone graft, onlay or interpositional (includes obtaining autograft)
21137 Reduction forehead; contouring only **(Report required)**
21138 contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139 contouring and setback of anterior frontal sinus wall **(Report required)**
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) **(Report required)**

21151 any direction, requiring bone grafts (includes obtaining autografts) **(Report required)**

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 **(Report required)**

21160 with LeFort I **(Report required)**

21172 Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)

(For frontal or parietal craniotomy performed for craniosynostosis, use 61556)

21175 Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)

(For bifrontal craniotomy performed for craniosynostosis, use 61557)

21179 Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material) **(Report required)**

21180 with autograft (includes obtaining grafts)

(For extensive craniectomy for multiple suture craniosynostosis, use only 61558 or 61559)

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 **(Report required)**

21183 total area of bone grafting greater than 40 sq cm but less than 80 sq cm **(Report required)**

21184 total area of bone grafting greater than 80 sq cm **(Report required)**

(For excision of benign tumor of cranial bones, see 61563, 61564)

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) **(Report required)**
21195 Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation **(Report required)**
21196 with internal rigid fixation
21198 Osteotomy, mandible, segmental;
21199 with genioglossus advancement

(To report total osteotomy of the maxilla, see 21141-21160)

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)

(For cleft palate repair, see 42200-42225)

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)

(To report graft augmentation of facial bones, use 21208)

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 **(Report required)**
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 **(Report required)**

(To report midface reconstruction, see 21141-21160)

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 **(Report required)**
21263 with forehead advancement
21267 Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268 combined intra- and extracranial approach **(Report required)**

21270 Malar augmentation, prosthetic material

(For malar augmentation with bone graft, see 21210)

21275 Secondary revision of orbitocraniofacial reconstruction
21280 Medial canthopexy (separate procedure)

(For medial canthoplasty, use 67950)

21282 Lateral canthopexy
21295 Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach **(Report required)**
21296 intraoral approach **(Report required)**

OTHER PROCEDURES

21299 Unlisted craniofacial and maxillofacial procedure

FRACTURE AND/OR DISLOCATION

(For operative repair of skull fracture, see 62000-62010)
(To report closed treatment of skull fracture, use the appropriate evaluation and management code)

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 Percutanous 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)

(For removal of internal or external fixation device, use 20670)

21436 complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft) **(Report required)**
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 **(Report required)**
21490 Open treatment of temporomandibular dislocation

(For interdental wire fixation, use 21497)

21495 Open treatment of hyoid fracture **(Report required)**

(For laryngoplasty with open reduction of fracture, use 31584)
(To report treatment of closed fracture of larynx, use the applicable evaluation and management codes)

OTHER PROCEDURES

21497 Interdental wiring, for condition other than fracture **(Report required)**
21499 Unlisted musculoskeletal procedure, head

(For unlisted craniofacial or maxillofacial procedure, use 21299)

NECK (SOFT TISSUES) AND THORAX

(For cervical spine and back, see 21920 et seq)
(For injection of fracture site or trigger point, see 20550)

INCISION

(For incision and drainage of abscess or hematoma, superficial, see 10060, 10140)

21501 Incision and drainage, deep abscess or hematoma, soft tissues of neck of thorax;

(For posterior spine subfascial incision and drainage, see 22010-22015)

21502 with partial rib ostectomy
21510 Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax

EXCISION

(For bone biopsy, see 20220-20251)

21550 Biopsy, soft tissue of neck or thorax

(For needle biopsy of soft tissue, use 20206)

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, malignant neoplasm), soft tissue of neck or anterior thorax; less than 5 cm
21558 5 cm or greater
21600 Excision of rib, partial

(For radical resection of chest wall and rib cage for tumor, use 19260)
(For radical debridement of chest wall and rib cage for injury, see 11040-11044)

21610 Costotransversectomy (separate procedure)
21615 Excision first and/or cervical rib;
21616 with sympathectomy
21620 Ostectomy of sternum, partial
21627 Sternal debridement

(For debridement and closure, use 21750)

21630 Radical resection of sternum;
21632 with mediastinal lymphadenectomy

REPAIR, REVISION AND/OR RECONSTRUCTION

(For superficial wound, see Integumentary System section under REPAIR-SIMPLE)

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

(For transection of spinal accessory and cervical nerves, see 63191, 64722)

21725 with cast application
21740 Reconstructive repair of pectus excavatum or carinatum; open
21742 minimally invasive approach (Nuss procedure), without thoracoscopy **(Report required)**
21743 minimally invasive approach (Nuss procedure), with thorascopy **(Report required)**
21750 Closure of median sternotomy separation with or without debridement (separate procedure)

FRACTURE AND/OR DISLOCATION

21800 Closed treatment of rib fracture, uncomplicated, each
21805 Open treatment of rib fracture without fixation, each **(Report required)**
21810 Treatment of rib fracture requiring external fixation (flail chest) **(Report required)**
21820 Closed treatment of sternum fracture
21825 Open treatment of sternum fracture with or without skeletal fixation

(For sternoclavicular dislocation, see 23520-23532)

OTHER PROCEDURES

21899 Unlisted procedure, neck or thorax

BACK AND FLANK

EXCISION

21920 Biopsy, soft tissue of back or flank; superficial
21925 deep

(For needle biopsy of soft tissue, use 20206)

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, malignant neoplasm), 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. Instrumentation procedure codes 22840-22848 and 22851 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 and 22850-22852. 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 Ll-L3, utilizing anterior instrumentation Ll-L3 and structural allograft. Report as 63090,22558-51, 22585, 22845 and 20931.

(Do not append modifier 62 to bone graft code 20931)
(For injection procedure for myelography, use 62284)
(For injection procedure for discography, see 62290, 62291)
(For injection procedure, chemonucleolysis, single or multiple levels, use 62292)
(For injection procedure for facet joints, see 64490-64495, 64622-64627)
(For needle or trocar biopsy, see 20220-20225)

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)

(For incision and drainage of abscess or hematoma, superficial, see 10060, 10140)

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.

(For bone biopsy, see 20220-20251)
(To report soft tissue biopsy of back or flank, see 21920-21925)
(For needle biopsy of soft tissue, use 20206)
(To report excision of soft tissue tumor of back or flank, use 21930)

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)

(For complete or near complete resection of vertebral body, see vertebral corpectomy, 63081-63091)

(For spinal reconstruction with bone graft (autograft, allograft) and/or methylmethacrylate of cervical vertebral body, use 63081 and 22554 and 20931 or 20938)

(For spinal reconstruction with bone graft (autograft, allograft) and/or methylmethacrylate of thoracic vertebral body, use 63085 or 63087 and 22556 and 20931 or 20938)

(For spinal reconstruction with bone graft (autograft, allograft) and/or methylmethacrylate of lumbar vertebral body, use 63087 or 63090 and 22558 and 20931 or 20938)

(For spinal reconstruction following vertebral body resection, use 63082 or 63086 or 63088 or 63091, and 22585)

(For harvest of bone autograft for vertebral reconstruction, see 20931 or 20938)

(For cervical spinal reconstruction with prosthetic replacement of resected vertebral bodies, see codes 63081 and 22554 and 20931 or 20938 and 22851)

(For thoracic spinal reconstruction with prosthetic replacement of resected vertebral bodies, see codes 63085 or 63087 and 22556 and 20931 or 20938 and 22851)

(For lumbar spinal reconstruction with prosthetic replacement of resected vertebral bodies, see codes 63087 or 63090 and 22558, and 20931 or 20938 and 22851)

(For osteotomy of spine, see 22210-22226)

OSTEOTOMY

To report arthrodesis, see codes 22590-22632. (Report in addition to code(s) for the definitive procedure)

To report instrumentation procedures, see codes 22840-22855.(Report in addition to code(s) for 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 20930-20938. (Report in addition to code(s) for the definitive procedure(s). Do not append modifier –62 to bone graft codes 20900-20938.

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 posteriolateral 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 posteriolateral 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 diskectomy, 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)

(For vertebral corpectomy, see 63081-63091)

FRACTURE AND/OR DISLOCATION

To report arthrodesis, see codes 22590-22632. (Report in addition to code(s) for the definitive procedure)

To report instrumentation procedures, see codes 22840-22855. (Report in addition to code(s) for 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 20930-20938. (Report in addition to code(s) for the definitive procedure(s)).

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

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.

22305 Closed treatment of vertebral process fracture(s)
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, with or without anesthesia, 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 **(Report required)**

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)

(For treatment of vertebral fracture by the anterior approach, see corpectomy 63081-63091, and appropriate arthrodesis, bone graft and instruments codes)
(For decompression of spine following fracture, see 63001-63091)
(For arthrodesis of spine following fracture, see 22548-22632)

MANIPULATION

22505 Manipulation of spine requiring anesthesia, any region

VERTEBRAL BODY, EMBOLIZATION OR INJECTION

22520 Percutaneous vertebroplasty, 1 vertebral body, unilateral or bilateral injection; thoracic

22521 lumbar

22522 each additional thoracic or lumbar vertebral body
(List separately in addition to primary procedure)
(Use 22522 in conjunction with codes 22520, 22521 as appropriate)

(For radiological supervision and interpretation, see 72291, 72292)

22523 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic

22524 lumbar

22525 each additional thoracic or lumbar vertebral body
(List separately in addition to primary procedure)
(D not report 22525 in conjunction with 20225 when performed at the same level as 22523-22525)
(Ue 22525 in conjunction with 22523, 22524)
(For radiological supervision and interpretation, see 72291, 72292)

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

To report instrumentation procedures, see 22840-22855. (Report in addition to code(s) for the definitive procedure(s)).
Do not append modifier –62 to spinal instrumentation codes 22840-22848 and 22850-22852.
To report exploration of fusion, use 22830.
To report bone graft procedures, see codes 20930-20938. (Report in addition to code(s) for the definitive procedure(s)).
Do not append modifier –62 to bone graft codes 20900-20938.

LATERAL EXTRACAVITARY APPROACH TECHNIQUE

22532 Arthrodesis, lateral extracavitary technique, including minimal diskectomy 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 disk, 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

(For intervertebral disk excision by laminotomy or laminectomy, see 63020-63042)

22554 Arthrodesis, anterior interbody technique, including minimal diskectomy 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)

POSTERIOR, POSTEROLATERAL OR LATERAL TRANSVERSE PROCESS TECHNIQUE

To report instrumentation procedures, see codes 22840-22855. (Report in addition to code(s) for 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 20930-20938. (Report in addition to code(s) for the 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.

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 or without lateral transverse technique)
22612 lumbar (with or without lateral transverse technique)
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 diskectomy 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)

SPINE DEFORMITY (EG, SCOLIOSIS, KYPHOSIS)

To report instrumentation procedures, see codes 22840-22855. (Report in addition to code(s) for 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 20930-20938. (Report in addition to code(s) for the definitive procedures(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.

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

(To report bone graft procedures, see 20930-20938)

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 and 22851 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 20930-20938. (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, 22851 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)
(Use 22840 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

22841 Internal spinal fixation by wiring of spinous processes
(List separately in addition to primary procedure)
(Use 22841 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

22842 Posterior segmental instrumentation (eg, pedical fixation, dual rods with multiple hooks and sublaminal wires); 3 to 6 vertebral segments
(List separately in addition to primary procedure)
(Use 22842 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

22843 7 to 12 vertebral segments
(List separately in addition to primary procedure)
(Use 22843 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

22844 13 or more vertebral segments
(Use 22844 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

22845 Anterior instrumentation; 2 to 3 vertebral segments
(List separately in addition to primary procedure)
(Use 22845 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

22846 4 to 7 vertebral segments
(Use 22846 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

22847 8 or more vertebral segments
(Use 22847 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

22848 Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum
(List separately in addition to primary procedure)
(Use 22848 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

22849 Reinsertion of spinal fixation device

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

22851 Application of intervertebral biomechanical device(s) (eg, synthetic cages, threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace
(List separately in addition to primary procedure)
(Use 22851 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

22852 Removal of posterior segmental instrumentation

22855 Removal of anterior instrumentation

(For spinal cord monitoring use 95925)

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
(Do not report 22856 in conjunction with 22554, 22845, 22851, 63075 when performed at the same level)

22857 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar
(Do not report 22857 in conjunction with 22558, 22845, 22851, 49010 when performed at the same level)

22861 Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
(Do not report 22861 in conjunction with 22845, 22851, 22864, 63075 when performed at the same level)

22862 lumbar
(Do not report 22862 in conjunction with 22558, 22845, 22851, 22865, 49010 when performed at the same level)

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
(Do not report 22865 in conjunction with 49010)

(22857-22865 include fluoroscopy when performed)

(For decompression, see 63001-63048)

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, malignant neoplasm), 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

(For arthroscopic removal of bursal deposits, use 29999)

23020 Capsular contracture release (eg, Sever type procedure)

(For incision and drainage procedures, superficial, see 10040-10160)

23030 Incision and drainage, shoulder area; deep abscess or hematoma
23031 infected bursa
23035 Incision, bone cortex (eg, for 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

(For needle biopsy of soft tissue, use 20206)

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, malignant neoplasm), 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

(For arthroscopic procedure, use 29824)

23125 total
23130 Acromioplasty or acromionectomy, partial, with or without coracacromial 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

(For replacement with implant, use 23470)

23200 Radical resection of tumor; clavicle
23210 scapula
23220 Radical resection of tumor, proximal humerus

INTRODUCTION OR REMOVAL

(For arthrocentesis or needling of bursa, see 20610)
(For K-wire or pin insertion or removal, see 20650, 20670, 20680)

23330 Removal of foreign body, shoulder; subcutaneous
23331 deep (eg, Neer hemiarthroplasty removal)
23332 complicated (eg, total shoulder) **(Report required)**
23350 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

(For radiographic arthrography, radiological supervision and interpretation, use 73040. Fluoroscopy (77002) is inclusive of radiographic arthrography)

(When fluoroscopic guided injection is performed for enhanced CT arthrography, use 23350, 77002, and 73201 or 73202)

(When fluoroscopic guided injection is performed for enhanced MR arthrography, use 23350, 77002, and 73222 or 73223)

(For enhanced CT or enhanced MRI arthrography, use 77002 and either 73201, 73202, 73222 or 73223)

(To report biopsy of the shoulder and joint, see 29805-29826)

REPAIR, REVISION AND/OR RECONSTRUCTION

23395 Muscle transfer, any type, shoulder or upper arm; single
23397 multiple
23400 Scapulopexy (eg, Sprengel's 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

(For arthroscopic procedure, use 29827)

23415 Coracoacromial ligament release, with or without acromioplastym

(For arthroscopic procedure, use 29826)

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

(To report arthroscopic thermal capsulorrhaphy, use 29999)

23455 with labral repair (eg, Bankart procedure)

(For arthroscopic procedure, use 29806)

23460 Capsulorrhaphy, anterior, any type; with bone block
23462 with coracoid process transfer

(To report open thermal capsulorrhaphy, use 23929)

23465 Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block

(For sternoclavicular and acromioclavicular reconstruction, see 23530 and 23550)

23466 Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
23470 Arthroplasty, glenohumeral joint; hemiarthoplasty
23472 total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)

(For removal of total shoulder implants, see 23331, 23332)
(For osteotomy proximal humerus, use 24400)

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

(Repairs for recurrent dislocations, see 23450-23466)

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; **(Report required)**
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

(For incision/drainage procedures, superficial, see 10040 - 10160)

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 (sufascial or intramuscular)

(For needle biopsy of soft tissue, use 20206)

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 fupper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm
24077 Radical resection of tumor (eg, malignant neoplasm), 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

(For replacement with implant, use 24366)

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)

(For capsular and soft tissue release only, use 24006)

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

(For K-wire or pin insertion or removal, see 20650, 20670, 20680)
(For arthrocentesis or needling of bursa or joint, use 20605)

24160 Implant removal; elbow joint
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
(For radiological supervision and interpretation, use 73085. Do not report 77002 in conjunction with 73085)

(For injection of tennis elbow, use 20550)

REPAIR, REVISION AND/OR RECONSTRUCTION

24300 Manipulation, elbow, under anesthesia

(For application of external fixation, see 20690 or 20692)

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
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)

(For proximal radius and/or ulna, see 25400-25420)

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

(To report closed treatment of fractures without manipulation, see 24530, 24560, 24576, 24650, 24670)
(To report closed treatment of fractures with manipulation, see 24535, 24565, 24577, 24675)

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 reamputation
24931 with implant
24935 Stump elongation, upper extremity **(Report required)**
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)

(For decompression median nerve or for carpal tunnel syndrome, use 64721)

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

(For decompression fasciotomy with brachial artery exploration, use 24495)
(For incision and drainage procedures, superficial, see 10060-10160)
(For debridement, see also 11000-11044)

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)

(For needle biopsy of soft tissue, use 20206)

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, malignant neoplasm), 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

(For hand or finger, use 26160)

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)

(For finger synovectomies, use 26145)

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);

(For head or neck of radius or olecranon process, see 24120-24126)

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

(For head or neck of radius or olecranon process, see 24145-24147)

25170 Radical resection for tumor, radius or ulna

25210 Carpectomy; one bone

(For carpectomy with implant, see 25441-25445)

25215 all bones of proximal row
25230 Radial styloidectomy (separate procedure)
25240 Excision distal ulna partial or complete (eg, Darrach type or matched resection)

(For implant replacement, distal ulna, see 25442)
(For obtaining fascia for interposition, see 20920, 20922)

INTRODUCTION OR REMOVAL

(For K-wire, pin, or rod insertion or removal, see 20650, 20670, 20680)

25246 Injection procedure for wrist arthrography
(For radiological supervision and interpretation, use 73115. Do not report 77002 in conjunction with 73115)

(For foreign body removal, superficial, use 20520)

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

(For application of external fixation, see 20690 or 20692)

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

(For obtaining fascia for interposition, see 20920-20922)
(For prosthetic replacement arthroplasty, see 25441-25446)

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

(For harvesting of fascia lata graft, see 20920, 20922)

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 carpo-metacarpal joints

(For wrist arthroplasty, see 25332)

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

(For application of external fixation in addition to internal fixation, use 20690 and the appropriate internal fixation code)

(Do not report 25600, 25605, 25606, 25607, 25608, 25609, in conjunction with 25650)

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

(For 25606, 25607, 25609 for percutaneous treatment of ulnar styloid fracture, use 25651)
(For 25606, 25607, 25609 for open treatment of ulnar styloid fracture, use 25652)

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) **(Report required)**
26037 Decompressive fasciotomy, hand (excludes 26035)

(For injection injury, see 26035)

26040 Fasciotomy, palmar, (eg, Dupuytren's contracture); percutaneous
26045 open, partial

(For fasciectomy, see 26121-26125)

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, malignant neoplasm), 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 promixal 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)

(For fasciotomy, see 26040, 26045)

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 tendor, palm and/or finger, each tendon

(For tendon sheath synovectomies at wrist, see 25115, 25116)

26160 Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger

(For wrist ganglion, see 25111, 25112)
(For trigger digit, see 26055)

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

(For removal of foreign body in hand or finger, see 20520, 20525)

REPAIR, REVISION AND/OR RECONSTRUCTION

26340 Manipulation, finger joint, under anesthesia, each joint

(For application of external fixation, see 20690 or 20692)

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 **(Report required)**
26416 Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod **(Report required)**
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)

(For tenovaginotomy for trigger finger, use 26055)

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

(For thumb fusion in opposition, use 26820)

26497 Transfer of tendon to restore intrinsic function; ring and small finger
26498 all four fingers
26499 Correction claw finger, other methods **(Report required)**
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 **(Report required)**
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

(To report carpometacarpal joint arthroplasty, use 25447)

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 **(Report required)**

(For great toe with web space, use 20973)

26553 other than great toe, single **(Report required)**
26554 other than great toe, double **(Report required)**
26555 Transfer, finger to another position without microvascular anastomosis **(Report required)**
26556 Transfer, free toe joint**,** with microvascular anastomosis **(Report required)**

(To report great toe-to-hand transfer, use 20973)

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 **(Report required)**
26580 Repair cleft hand **(Report required)**
26587 Reconstruction of polydactylous digit, soft tissue and bone

(For excision of polydactylous digit, soft tissue only, use 11200)

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

(To report release of scar contracture or graft repairs see 11041-11042, 14040-14041, or 15120, 15240)

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 metacarpo-phalangeal 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

(For hand through metacarpal bones, use 25927)

26910 Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseus transfer

(For repositioning, see 26550, 26555)

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)

(For repair of soft tissue defect requiring split or full thickness graft or other pedicle flaps, see 15050-15758)

OTHER PROCEDURES

26989 Unlisted procedure, hands or fingers

PELVIS AND HIP JOINT

Including head and neck of femur.

INCISION

(For incision and drainage procedures, superficial, see 10040-10160)

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, report 27027 with 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 **(Report required)**

(For obturator neurectomy, see 64763, 64766)

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

(For needle biopsy of soft tissue, use 20206)

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, malignant neoplasm),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, report 27057 with modifier 50)

27059 Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; 5 cm or greater
27060 Excision; ischial bursa
27062 trochanteric bursa or calcification
(For arthrocentesis or needling of bursa, see 20610)

27065 Excision of bone cyst or benign tumor; superficial (wing or ilium, symphysis pubis, or greater trochanter of femur) with or without autograft
27066 deep, with or without autograft
27067 with autograft requiring separate incision
27070 Partial excision (craterization, saucerization) (eg, osteotomyelitis or bone abscess); superficial (eg, wing of ilium, symphysis pubis or greater trochanter of femur)
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

(For pressure (decubitus) ulcer, see 15920, 15922 and 15931-15958)

INTRODUCTION OR REMOVAL

27086 Removal of foreign body, pelvis or hip; subcutaneous tissue
27087 deep (subfacial 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, arthrography and/or anesthetic/steroid
(27096 is to be used only with imaging confirmation of intra-articular needle positioning)
(27096 is a unilateral procedure. For bilateral procedure, use modifier -50)

(For radiological supervision and interpretation, of sacroiliac joint arthrography use 73542)
(For fluoroscopic guidance without formal arthrography, use 77003)

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) **(Report required)**
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)

(For prosthetic replacement following fracture of hip, use 27236)

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

27193 Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation
27194 with manipulation, requiring more than local anesthesia
27200 Closed treatment of coccygeal fracture
27202 Open treatment of coccygeal fracture **(Report required)**
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, pertrochanteric, or subtrochanteric femoral fracture; without manipulation
27240 with manipulation, with or without skin or skeletal traction
27244 Treatment of intertrochanteric, pertrochanteric 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

(For treatment of acetabular fracture with fixation, see 27226, 27227)

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

27280 Arthrodesis, sacroiliac joint (including obtaining graft) **(Report required)**
(To report bilateral procedures, use modifier -50)

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

AMPUTATION

27290 Interpelviabdominal amputation (hind quarter amputation) **(Report required)**
27295 Disarticulation of hip

OTHER PROCEDURES

27299 Unlisted procedure, pelvis or hip joint

FEMUR (THIGH REGION) AND KNEE JOINT

Including tibial plateaus.

INCISION

(For incision/drainage of abscess/hematoma, superficial, see 10040-10160)

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

(For combined Ober-Yount fasciotomy, see 27025)

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 (subfacial or intramuscular)

(For needle biopsy of soft tissue, use 20206)

27325 Neurectomy, hamstring muscle **(Report required)**
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, malignant neoplasm), soft tissue of thigh or knee area; less than 5 cm
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 5 cm or greater
27365 Radical resection of tumor, bone, femur or knee

(For radical resection of tumor, soft tissue, use 27329)

INTRODUCTION OR REMOVAL

27370 Injection procedure for knee arthrography
(For radiological supervision and interpretation, use 73580. Do not report 77002 in conjunction with 73580)

27372 Removal foreign body, deep, thigh region or knee area

(For removal of knee prosthesis including "total knee", use 27488)
(For surgical arthroscopic knee procedures, see 29870-29887)

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

(For arthroscopic repair, use 29882)

27405 Repair, primary, torn ligament and/or capsule, knee; collateral
27407 cruciate

(For cruciate ligament reconstruction, use 27427)

27409 collateral and cruciate ligaments

(For ligament reconstruction, see 27427-27429)

27415 Osteochondral allograft, knee, open

(For arthroscopic implant of osteochondral allograft, use 29867)

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)

(For arthroscopic osteochondral autograft of knee, use 29866)

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

(For arthroscopic lateral release, use 29873)

27427 Ligamentous reconstruction (augmentation), knee; extra-articular
27428 intra-articular (open)
27429 intra-articular (open) and extra-articular **(Report required)**

(For primary repair of ligament(s) performed in conjunction with reconstruction, report 27405, 27407 or 27409 in conjunction with 27427, 27428 or 27429)

27430 Quadricepsplasty (eg, Bennett or Thompson type)
27435 Capsulotomy, posterior release, knee
27437 Arthroplasty, patella; without prosthesis **(Report required)**
27438 with prosthesis **(Report required)**
27440 Arthroplasty, knee, tibial plateau;
27441 with debridement and partial synovectomy
27442 Arthroplasty, femoral condylesor 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)

(For revision of total knee arthroplasty, use 27487)
(For removal of total knee prosthesis, use 27488)

(To report 27448-27450, 27455-27457 as bilateral procedures, use modifier -50)

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
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, epiphydiodesis); 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

(For arthroscopic treatment of tibial fracture, see 29855, 29856)
(For arthroscopic treatment of intercondylar spine(s) and tuberosity fracture(s) of the knee, see 29850, 29851)

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 **(Report required)**
27517 with manipulation, with or without skin or skeletal traction **(Report required)**
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

(For arthroscopic treatment for 27532, 27536, see 29855, 29856)

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

(For arthroscopic treatment, see 29850, 29851)

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

(For recurrent dislocation, see 27420-27424)

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 reamputation
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)

(For incision/drainage procedures, superficial, see 10040-10160)
(For decompression fasciotomy with debridement, see 27892-27894)

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
(See also 27685)

EXCISION

27613 Biopsy, soft tissues; superficial
27614 deep (subfacial or intramuscular)

(For needle biopsy of soft tissue, use 20206)

27615 Radical resection of tumor (eg, malignant neoplasm), 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
(For exostosis excision, use 27635)

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)

(For ankle arthroscopy, see 29894-29898)

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 **(Report required)**
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)

(Toe extensors are considered as a group to be a single tendon when transplanted into midfoot)

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 hallicus 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 **(Report required)**
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)

(For osteotomy to correct genu varus (bowleg) or genu valgus (knock-knee), see 27455-27457)

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 **(Report required)**
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

(For epiphyseal arrest of proximal tibia and fibula, use 27477)

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

(For treatment of tibia and fibula shaft fractures, see 27750-27759)

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 tibal 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

(For surgical or diagnostic arthroscopic procedures, see 29894-29898)

MANIPULATION

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

ARTHRODESIS

27870 Arthrodesis, ankle, open

(For arthroscopic ankle arthrodesis, use 29899)

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 reamputation
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

(For decompression fasciotomy of the leg without debridement, use 27600)

27893 posterior compartment(s) only, with debridement of nonviable muscle and/or nerve

(For decompression fasciotomy of the leg without debridement, use 27601)

27894 anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve

(For decompression fasciotomy of the leg without debridement, use 27602)

27899 Unlisted procedure, leg or ankle

FOOT AND TOES

INCISION

(For incision and drainage procedures, superficial, see 10040-10160)

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

(For open tenotomy, see 28230-28234)

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)

(For other nerve entrapments, see 64704, 64722)

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, malignant neoplasm), 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)

(For plantar fasciotomy, see 28008, 28250)

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

(For ostectomy, partial (eg, hallux valgus, Silver type procedure), use 28290)

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 phyalangectomy, 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 calcaneous

(For partial excision of talus or calcaneus, use 28120)
(For cheilectomy for hallux rigidus, use 28289)

28124 phalanx of toe
28126 Resection, partial or complete, phalangeal base, each toe
28130 Talectomy (astragalectomy)

(For calcanectomy, use 28118)

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) **(Report required)**
28173 metatarsal
28175 phalanx of toe

(For talus or calcaneus, use 27647)

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

(For tendon transfer to midfoot or hindfoot, see 27690, 27691)

28238 Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)
(For subcutaneous tenotomy, see 28010, 28011)
(For transfer or transplant of tendon with muscle redirection or rerouting, see 27690-27692)
(For extensor hallucis longus transfer with great toe IP fusion (Jones procedure), use 28760)

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 Syndactylism, (eg, webbing or Kelikian type procedure)
28285 Correction, hammertoe;(eg, interphalangeal fusion, partial or total phalangectomy)
28286 Correcting 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
28290 Correction hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (Silver type procedure)
28292 Keller, McBride or Mayo type procedure
28293 resection of joint with implant
28294 with tendon transplants (Joplin type procedure)
28296 with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)
28297 Lapidus type procedure
28298 by phalanx osteotomy
28299 by double osteotomy
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) **(Report required)**
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)

(For arthroscopic osteochondral talus graft, use 29892)
(For open osteochondral allograft or repairs with industrialgrafts, use 27599)

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 **(Report required)**
28531 Open treatment of sesamoid fracture, with or without internal fixation **(Report required)**
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 metatarso phalangeal 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)

(For hammertoe operation or interphalangeal fusion, use 28285)

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

(See 20661-20663 for insertion)

29010 Application of Risser jacket, localizer, body; only
29015 including head
29020 Application of turnbuckle jacket, body; only
29025 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

(For hip spica (body) cast, including thighs only, use 29046)

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 venous wound compression system, below knee
29590 Denis-Browne splint strapping

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
29715 turnbuckle jacket
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
(For open procedure, use 21010)

29805 Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
(For open procedure, see 23065-23066, 23100-23101)

29806 Arthroscopy, shoulder, surgical; capsulorrhaphy
(For open procedure, see 23450-23466)

(To report thermal capsulorrhaphy, use 29999)

29807 repair of slap lesion
29819 Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
(For open procedure, see 23040-23044, 23107)

29820 synovectomy, partial
29821 synovectomy, complete

(For 29820 and 29821, for open procedure, see 23105)

29822 debridement, limited
29823 debridement, extensive

(For 29822 and 29823, for open procedures, see specific open shoulder procedure performed)

29824 Arthroscopy, distal claviculectomy including distal articular surface (Mumford procedure)
(For open procedure, use 23120)

29825 with lysis and resection of adhesions with or without manipulation
(For open procedures, see specific open shoulder procedure performed)

29826 decompression of subacromial space with partial acromioplasty with or without coracoacromial release
(For open procedure, use 23130 or 23415)

29827 with rotator cuff

(For open or mini-open rotator cuff repair, use 23412)
(When arthroscopic subacromial decompression is performed at the same setting, use 29826)
(When arthroscopic distal clavicle resection is performed at the same setting, use 29824)

29828 Arthroscopy, shoulder, surgical; biceps tenodesis
(Do not report 29828 in conjunction with 29805, 29820, 29822)

(For open biceps tenodesis, use 23430)

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
(For open procedure, use 64721)

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)

(For bone graft, use 20900, 20902)

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)

(For bone graft, use 20900, 20902)

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)

(For open osteochondral autograft of knee, use 27416)

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

(For open lateral release, use 27425)

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)
29881 with meniscectomy (medial OR lateral, including any meniscal shaving)
29882 with meniscus repair (medial OR lateral)
29883 with meniscus repair (medial AND lateral)

(For meniscal transplantation, medial or lateral, knee, use 29868)

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

(For open ankle arthrodesis, use 27870)

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
29999 Unlisted procedure, arthroscopy

RESPIRATORY SYSTEM

NOSE

INCISION

30000 Drainage abscess or hematoma, nasal, internal approach

(For external approach, see 10060, 10140)

30020 Drainage abscess or hematoma, nasal septum

(For lateral rhinotomy, see specific application, eg, 30118, 30320)

EXCISION

30100 Biopsy, intranasal

(For biopsy skin of nose, see 11100, 11101)

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

(For excision of superior or middle turbinate, use 30999)

30140 Submucous resection inferior turbinate, partial or complete, any method

(Do not report 30130 or 30140 in conjunction with 30801, 30802, 30930)

(For submucous resection of superior or middle turbine, use 30999)
(For endoscopic resection of concha bullosa of middle turbinate, use 31240)
(For submucous resection of nasal septum, see 30520)

30150 Rhinectomy; partial
30160 total

(For closure and/or reconstruction, primary or delayed, see Integumentary System, 13150-13160, 14060-14302, 15120, 15121, 15260, 15261, 15760, 20900-20912)

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

(For obtaining tissues for graft, see 20900-20926, 21210)

30400 Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip

(For columellar reconstruction, see 13150 et seq)

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)

30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

(For submucous resection of turbinates, use 30140)

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

(For ablation of superior or middle turbinates, use 30999)

30802 Intramural; (ie, submucosal)

(Do not report 30801in conjunction with 30802)
(Do not report 30801, 30802, 30930 in conjunction with 30130 or 30140)

(For cautery performed for control of nasal hemorrhage, see 30901-30906)

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

(For ligation external carotid artery, use 37600)

30930 Fracture nasal inferior turbinate(s), therapeutic

(Do not report 30801, 30802, 30930 in conjunction with 30130 or 30140)

(For fracture of superior or middle turbinate(s), use 30999)

30999 Unlisted procedure, nose

ACCESSORY SINUSES

INCISION

(For 31000, 31020, 31030, 31032, to report bilateral procedures, use modifier -50)

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 **(Report required)**

(For transantral ligation of internal maxillary artery, use 30920)

31050 Sinusotomy, sphenoid, with or without biopsy;

31051 with mucosal stripping or removal of polyp(s)

31070 Sinusotomy frontal; external, simple (trephine operation)

(For frontal intranasal sinusotomy, use 31276)

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)

(For orbital exenteration only, see 65110 et seq)
(For skin grafts, see 15120 et seq)

ENDOSCOPY

A surgical sinus endoscopy always includes a sinusotomy (when appropriate) and diagnostic endoscopy. Codes 31231-31294 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

(For endoscopic osteomeatal complex (OMC) resection with antrostomy and/or anterior ethmoidectomy, with or without removal of polyp(s), use 31254 and 31256)

(For endoscopic osteomeatal complex (OMC) resection with antrostomy, removal of antral mucosal disease, and/or anterior ethmoidectomy, with or without removal of polyp(s), use 31254 and 31267)

(For endoscopic frontal sinus exploration, osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s), use 31254 and 31276)

(For endoscopic frontal sinus exploration, osteomeatal complex (OMC) resection, antrostomy, and/or anterior ethmoidectomy, with or without removal of polyp(s), use 31254, 31256, and 31276)

(For endoscopic nasal diagnostic endoscopy, see 31231-31235)

(For endoscopic osteomeatal complex (OMC) resection, frontal sinus exploration, antrostomy, removal of antral mucosal disease, and/or anterior ethmoidectomy, with or without removal of polyp(s), use 31254, 31267, and 31276)

31254 Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)

31255 with ethmoidectomy, total (anterior and posterior)

31256 Nasal/sinus endoscopy, surgical, with maxillary antrostomy;

(For endoscopic anterior and posterior ethmoidectomy (APE) and antrostomy, with or without removal of polyp(s), use 31255 and 31256)

(For endoscopic anterior and posterior ethmoidectomy (APE), antrostomy and removal of antral mucosal disease, with or without removal of polyp(s), use 31255 and 31267)

(For endoscopic anterior and posterior ethmoidectomy (APE), and frontal sinus exploration, with or without removal of polyp(s), use 31255 and 31276)

31267 with removal of tissue from maxillary sinus

(For endoscopic anterior and posterior ethmoidectomy (APE), and frontal sinus exploration and antrostomy, with or without removal of polyp(s), use 31255, 31256, and 31276)

(For endoscopic anterior and posterior ethmoidectomy (APE), frontal sinus exploration, antrostomy, and removal of antral mucosal disease, with or without removal of polyp(s), use 31255, 31267, and 31276)

31276 Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus

(For endoscopic anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s), use 31255, 31287 or 31288)

(For endoscopic anterior and posterior ethmoidectomy and sphenoidotomy (APS), and antrostomy, with or without removal of polyp(s), use 31255, 31256, and 31287 or 31288)

(For endoscopic anterior and posterior ethmoidectomy and sphenoidotomy (APS), antrostomy and removal of antral mucosal disease, with or without removal of polyp(s), use 31255, 31267, and 31287 or 31288)

(For endoscopic anterior and posterior ethmoidectomy and sphenoidotomy (APS), and frontal sinus exploration with or without removal of polyp(s), use 31255, 31287 or 31288, and 31276)

(For endoscopic anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s), with frontal sinus exploration and antrostomy, use 31255, 31256, 31287 or 31288, and 31276)

(For unilateral endoscopy of two or more sinuses, see 31231-31235)

(For endoscopic anterior and posterior ethmoidectomy and sphenoidotomy (APS), frontal sinus exploration, antrostomy and removal of antral mucosal disease, with or without removal of polyp(s), see 31255, 31267, 31287 or 31288 and 31276)

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 medial or inferior orbital wall decompression
31293 with medial orbital wall and inferior orbital wall decompression
31294 with optic nerve decompression

(For hypophysectomy, transantral or transeptal approach, use 61548)
(For transcranial hypophysectomy, use 61546)

OTHER PROCEDURES

31299 Unlisted procedure, accessory sinuses

LARYNX

EXCISION

31300 Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectomy
31320 diagnostic
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

(For endoscopic arytenoidectomy, use 31560)

31420 Epiglottidectomy

INTRODUCTION

31500 Intubation, endotracheal, emergency procedure

(For injection procedure for segmental bronchography, use 31656)

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 **(Report required)**
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 **(Report required)**
31528 with dilation, initial
31529 with dilation, subsequent **(Report required)**
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)

(For reconstruction of vocal cord with allograft, use 31599)

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 fiberscopic; diagnostic
31576 with biopsy
31577 with removal of foreign body
31578 with removal of lesion

(To report flexible fiberoptic endoscopic evaluation of swallowing, see 92612-92613)
(To report flexible fiberoptic endoscopic evaluation with sensory testing, see 92614-92615)

(To report flexible fiberoptic endoscopic evaluation of swallowing with sensory testing, see 92616-92617)
(For flexible fiberoptic laryngoscopy as part of flexible fiberoptic endoscopic evaluation of swallowing and/or laryngeal sensory testing by cine or video recording, see 92612-92617)

31579 Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy

REPAIR

31580 Laryngoplasty; for laryngeal web, two stage, with keel insertion and removal
31582 for laryngeal stenosis, with graft or core mold, including tracheotomy
31584 with open reduction of fracture
31587 Laryngoplasty, cricoid split
31588 Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy)
31590 Laryngeal reinnervation by neuromuscular pedicle

DESTRUCTION

31595 Section recurrent laryngeal nerve, therapeutic (separate procedure), unilateral **(Report required)**

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

(For endotracheal intubation, use 31500)
(For tracheal aspiration under direct vision, use 31515)

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 flouroscopic guidance, when performed.

(For tracheoscopy, see laryngoscopy codes 31515-31578)

31615 Tracheobronchoscopy through established tracheostomy incision

31620 Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s)
(List separately in addition to primary procedure(s))
(Use 31620 in conjunction with 31622-31646)

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)

(To report transbronchial lung biopsies performed on additional lobe, use 31632)

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)

(To report transbronchial needle aspiration biopsies performed on additional lobe(s), use 31633)

31630 with tracheal/bronchial dilation or closed reduction of fracture

31631 with placement of tracheal stent(s) (includes tracheal/ bronchial dilation as required)

(For placement of bronchial stent, see 31636, 31637)
(For revision of tracheal/bronchial stent, use 31638)

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)

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)

(For bronchoscopic photodynamic therapy, report 31641 in addition to 96570, 96571 as appropriate)

31643 with placement of catheter(s) for intracavitary radioelement application

(For intracavitary radioelement application, see 77761-77763, 777781-77784)

31645 with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess)

31646 with therapeutic aspiration of tracheobronchial tree, subsequent

(For catheter aspiration of tracheobronchial tree at bedside, use 31725)

31656 with injection of contrast material for segmental bronchography (fiberscope only)

(For radiological supervision and interpretation, see 71040, 71060)

INTRODUCTION

(For endotracheal intubation, see 31500)
(For tracheal aspiration under direct vision, see 31515)

31715 Transtracheal injection for bronchography
(For radiological supervision and interpretation, see 71040, 71060)

(For prolonged services, see 99354-99357)

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 **(Report required)**
31770 Bronchoplasty; graft repair
31775 excision stenosis and anastomosis

(For lobectomy and bronchoplasty, use 32501)

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

(For repair tracheoesophageal fistula, see 43305, 43312)

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
32095 Thoracotomy, limited, for biopsy of lung or pleura

(To report wound exploration due to penetrating trauma without thoractomy, use 20102)

32100 Thoracotomy, major; with exploration and biopsy
(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, with or without a pleural procedure
32141 with excision- plication of bullae, with or without any pleural procedure

(For lung volume reduction, use 32491)

32150 with removal of intrapleural foreign body or fibrin deposit
32151 with removal of intrapulmonary foreign body

32160 with cardiac massage

(For segmental or other resections of lung, see 32480-32504)

32200 Pneumonostomy; with open drainage of abscess or cyst
32201 with percutaneous drainage of abcess or cyst
(For radiological supervision and interpretation, use 75989)

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

(If imaging guidance is performed, see 76942, 77002, 77012, 77021)
(For fine needle aspiration, use 10021 or 10022)

32402 open
32405 Biopsy, lung or mediastinum, percutaneous needle
(For radiological supervision and interpretation see 76942, 77002, 77012, 77021)

(For fine needle aspiration, use 10022)

REMOVAL

32420 Pneumonocentesis, puncture of lung for aspiration
32421 Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent

(If imaging guidance is performed, see 76942, 77002, 77012)
(For total lung lavage, use 32997)

32422 Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)
(Do not report 32422 in conjunction with 19260, 19271, 19272, 32503, 32504)

(If imaging guidance is performed, see 76942, 77002, 77012)

32440 Removal of lung, total pneumonectomy
32442 with resection of segment of trachea followed by bronco-tracheal anastomosis (sleeve pneumonectomy) **(Report required)**
32445 extrapleural
(For extrapleural pneumonectomy, with empyemectomy, use 32445 and 32540)

(If lung resection is performed with chest wall tumor resection, report the appropriate chest wall tumor resection code, 19260-19272, in addition to lung resection code 32440-32445)

32480 Removal of lung, other than total pneumonectomy; single lobe (lobectomy)
32482 two lobes (bilobectomy)
32484 single segment (segmentectomy)

(For removal of lung with bronchoplasty, use 32501)

32486 with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)
32488 all remaining lung following previous removal of a portion of lung (completion pneumonectomy)

(For total or segmental lobectomy, with concomitant decortication, use 32320 and the appropriate removal of lung code)

32491 excision-plication of emphysematous lung(s), (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure
32500 wedge resection, single or multiple

(If lung resection is performed with chest wall tumor resection, report the appropriate chest wall tumor resection code, 19260-19272, in addition to lung resection code 32480-32500)

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, 32422, 32551)

(For performance of lung resection in conjunction with chest wall resection, see 19260, 19271, 19272 and 32480-32500, 32503, 32504)

32540 Extrapleural enucleation of empyema (empyemectomy);
(For extrapleural enucleation of empyema (empyemectomy) with lobectomy, use 32540 and the appropriate removal of lung code)

INTRODUCTION AND REMOVAL

32550 Insertion of indwelling tunneled pleural catheter with cuff
(Do not report 32550 in conjunction with 32421, 32422, 32551, 32560, 36000, 36410, 62318, 62319, 64450, 64490-64495).

(If imaging guidance is performed, use 75989)

32551 Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (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)

(For imaging guidance, see 76942, 77002, 77012, 77021)
(For percutaneous placement of interstitial device[s] for intra-abdominal, intrapelvic, and/or retroperitoneal radiation therapy guidance, use 49411)

DESTRUCTION

32560 Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)
(For chest tube insertion, use 32551)

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

32601 Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, without biopsy
32602 lungs and pleural space, with biopsy
32603 pericardial sac, without biopsy
32604 pericardial sac, with biopsy
32605 mediastinal space, without biopsy
32606 mediastinal space, with biopsy
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 excision-plication of bullae, including any pleural procedure
32656 with parietal pleurectomy
32657 with wedge resection of lung, single or multiple
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
32660 with total pericardectomy
32661 with excision of pericardial cyst, tumor, or mass
32662 with excision of mediastinal cyst, tumor, or mass

32663 with lobectomy, total or segmental
32664 with thoracic sympathectomy
32665 with esophagomyotomy (Heller type)

(For exploratory thoracoscopy, and exploratory thoracoscopy with biopsy, see 32601-32606)

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) **(Report required)**

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

(See also 32503, -32504)

32900 Resection of ribs, extrapleural, all stages
32905 Thoracoplasty, Schede type or extrapleural (all stages);
32906 with closure of bronchopleural fistula

(For open closure of major bronchial fistula, use 32815)
(For resection of first rib for thoracic outlet compression, see 21615, 21616)

32940 Pneumonolysis, extraperiosteal, including filling or packing procedures
32960 Pneumothorax, therapeutic, intrapleural injection of air

OTHER PROCEDURES

32997 Total lung lavage (unilateral)

(For bronchoscopic bronchial alveolar lavage, use 31624)

32998 Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral
(For imaging guidance and monitoring, see 76940, 77013, 77022)

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.

(For monitoring, operation of pump and other nonsurgical services, see 99190-99192, 99291, 99292, 99354-99357)

(For radiological supervision and interpretation, see 75600-75978)

HEART AND PERICARDIUM

PERICARDIUM

33010 Pericardiocentesis; initial
33011 subsequent

(For 33010, 33011, for radiological supervision and interpretation, use 76930)

33015 Tube pericardiostomy
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 Excision of pericardial cyst or tumor

CARDIAC TUMOR

33120 Excision of intracardiac tumor, resection with cardiopulmonary bypass
33130 Resection of external cardiac tumor **(Report required)**

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 33400-33496, 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-defbrillator 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 thoracosopic 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.

(For electronic, telephonic analysis of internal pacemaker system, see 93731-93736)
(For radiological supervision and interpretation with insertion of pacemaker use 71090)

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 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 or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular
33213 dual chamber

(Use 33212, 33213, as appropriate, in conjunction with the epicardial lead placement codes 33202, 33203 to report the insertion of the generator when done by the same physician during the same session)

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)
(When epicardial electrode placement is performed, report 33214 in conjunction with 33202, 33203)

33215 Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode
33216 Insertion of a single transvenous electrode, permanent pacemaker or cardioverter-defibrillator
33217 Insertion of 2 transvenous electrodes, permanent pacemaker or cardioverter-defibrillator

(Do not report 33216-33217 in conjunction with 33214)

33218 Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator

(For atrial or ventricular single chamber repair of pacemaker electrode(s) with replacement of pulse generator, see 33212 or 33213 and 33218 or 33220)

33220 Repair of two transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator

33222 Revision or relocation of skin pocket for pacemaker

33223 Revision of skin pocket for cardioverter-defibrillator

33224 Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion and/or replacement of generator)
(When epicardial electrode placement is performed, report 33224 in conjunction with 33202, 33203)

33225 Insertion of pacing electrode, cardiac venous system, for left ventrical pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including 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, 33222, 33233, 33234, 33235, 33240, 33249)

33226 Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of generator)

33233 Removal of permanent pacemaker pulse generator

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 single or dual chamber pacing of cardioverter-defibrillator pulse generator
(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 Subcutaneous removal of single or dual chamber pacing cardioverter-defibrillator pulse generator
(For removal of electrode(s) by thoracotomy, use 33243 in conjunction with 33241)
(For removal of electrode(s) by transvenous extraction, use 33244 in conjunction with 33241)
(For removal and reinsertion of a pacing cardioverter-defibrillator system (pulse generator and electrodes), report 33241 and 33243 or 33244 and 33249)

(For repair of implantable cardioverter-defibrillator pulse generator and/or leads, see 33218, 33220)

33243 Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by thoracotomy

33244 by transverse extraction

(For subcutaneous removal of the pulse generator, use 33241 in conjunction with 33243 or 33244)

33249 Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator
(For removal and reinsertion of a pacing cardioverter-defibrillator system (pulse generator and electrodes), report 33241 and 33243 or 33244 and 33249)

(For insertion of implantable cardioverter-defibrillator lead(s), without thoracotomy, use 33216)

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 solation 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 (33254-33256, 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. When 33254-33256 are performed with a concurrent procedure that requires a median sternotomy or cardiopulmonary bypass, report the operative (nonthoracoscopic) electrophysiologic procedure with unlisted procedure code 33999.

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

(Do not report 33254-33256 in conjunction with, 32100, 32551, 33120, 33130, 33210, 33211, 33400-33507, 33510-33523, 33533-33548, 33600-33853, 33860-33863, 33910-33920)

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)
(Use 33257 in conjunction with 33120-33130, 33250-33251, 33261, 33300-33335, 33400-33496, 33500-33507, 33510-33516, 33533-33548, 33600-33619, 33641-33697, 33702-33732, 33735-33767, 33770-33814, 33840-33877, 33910-33922, 33925-33926, 33935, 33945, 33975-33980)

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)
(Use 33258 in conjunction with 33130, 33250, 33300, 33310, 33320, 33321, 33330, 33332, 33401, 33414-33417, 33420, 33470-33472, 33501-33503, 33510-33516, 33533-33536, 33690, 33735, 33737, 33800-33813, 33840-33852, 33915, 33925 when the procedure is performed without cardiopulmonary bypass)

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)
(Use 33259 in conjunction with 33120, 33251, 33261, 33305, 33315, 33322, 33335, 33400, 33403-33413, 33422-33468, 33474-33478, 33496, 33500, 33504-33507, 33510-33516, 33533-33548, 33600-33688, 33692-33722, 33730, 33732, 33736, 33750-33767, 33770-33781, 33786-33788, 33814, 33853, 33860-33877, 33910, 33916-33922, 33926, 33935, 33945, 33975-33980 when the procedure is performed with cardiopulmonary bypass)

(Do not report 33257, 33258 and 33259 in conjunction with 32551, 33210, 33211, 33254-33256, 33265, 33266)

33261 Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass

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

(Do not report 33265-33266 in conjunction with 32551, 33210, 33211)

PATIENT-ACTIVATED EVENT RECORDER

33282 Implantation of patient-activated cardiac event recorder
(Initial implantation includes programming. For subsequent electronic analysis and/or reprogramming, use 93727)

33284 Removal of an implantable, patient-activated cardiac event recorder

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

(Do not report removal of thrombus (33310-33315) in conjunction with other cardiac procedures unless a separate incision in the heart is required to remove the atrial or ventricular thrombus)

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
33332 with shunt bypass **(Report required)**
33335 with cardiopulmonary bypass

CARDIAC VALVES

AORTIC VALVE

33400 Valvuloplasty, aortic valve; open, with cardiopulmonary bypass
33401 open, with inflow occlusion
33403 using transventricular dilation, with cardiopulmonary bypass **(Report required)**

(Do not report modifier –63 in conjunction with 33401, 33403)

33404 Construction of apical-aortic conduit
33405 Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve
33406 with allograft valve (freehand)

(For aortic valve valvotomy, (commissurotomy) with inflow occlusion, use 33401)
(For aortic valve valvotomy, (commissurotomy) with cardiopulmonary bypass, use 33403)

33410 with stentless tissue valve **(Report required)**
33411 Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp
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 hyertrophy)
33417 Aortoplasty (gusset) for supravalvular stenosis

MITRAL VALVE

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, 33472)

33470 Valvotomy, pulmonary valve, closed heart; transventricular
33471 via pulmonary artery

(To report percutaneous valvuloplasty of pulmonary valve, use 92990)

33472 Valvotomy, pulmonary valve, open heart; with inflow occlusion
33474 with cardiopulmonary bypass
33475 Replacement, pulmonary valve
33476 Right ventricular resection for infundibular stenosis, with or without commissurotomy
33478 Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection
(Use 33478 in conjunction with 33768 when a cavopulmonary anastomosis to a second superior vena cava is performed)

OTHER VALVULAR PROCEDURES

33496 Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure)
(For reoperation, use 33530 in addition to 33496)

CORONARY ARTERY ANOMALIES

Basic procedures include endarterectomy or angioplasty.
(Do not report modifier –63 in conjunction with 33502, 33503, 33505, 33506)

33500 Repair of coronary arteriovenous or arteriocardiac chamber fistula; with cardio-pulmonary bypass
33501 without cardio-pulmonary bypass **(Report required)**
33502 Repair of anomalous coronary artery from pulmonary artery origin; by ligation **(Report required)**
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)
(Use 35508 in conjunction with code 33510-33523)

(For open harvest of upper extremity vein procedure, use 35500)

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)
(Use 33530 in conjunction with 33400-33496; 33510-33536, 33863)

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)

(For Batista procedure or pachopexy, use 33999)

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

(For repair of pulmonary artery arborization anomalies by unifocalization, see 33925-33926)

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)

SEPTAL DEFECT

(Do not report modifier -63 in conjunction with 33647, 33670, 33690 or 33694)

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
(Do not report 33645 in conjunction with 33724, 33726)

33647 Repair of atrial septal defect and ventricular septal defect, with direct or patch closure

(For repair of tricuspid atresia (eg, fontan, gago procedures), use 33615)

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

(Do not report 33675-33677 in conjunction with 32100, 32422, 33210, 32551, 33681, 33684, 33688)

(For percutaneous closure, use 93581)

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

(For pulmonary vein repair requiring creation of atrial septal defect, use 33724)

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

(For ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure; see 33924)

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 **(Report required)**

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 infracardic types)

(For partial anomalous pulmonary venous return, use 33724; for repair of pulmonary venous stenosis, use 33726)

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 **(Report required)**

(For transvenous method cardiac catheterization balloon atrial septectomy or septostomy (rashkind type), use 92992)
(For blade method cardiac catheterization atrial septectomy or septostomy (sang-park septostomy), use 92993)

33750 Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation)
33755 ascending aorta to pulmonary artery (Waterston type operation) **(Report required)**
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)
(Use 33768 in conjunction with 33478, 33617, 33767)
(Do not report 33768 in conjunction with 32551, 33210, 33211)

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
(Do not report 33782 in conjunction with 33412, 33413, 33608, 33681, 33770, 33771, 33778, 33780, 33920)
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
(For pulmonary artery band, use 33690)

AORTIC ANOMALIES

33800 Aortic suspension (aortopexy) for tracheal decompression (eg, for tracheomalacia) (separate procedure)
33802 Division of aberrant vessel (vascular ring);
33803 with reanastomosis **(Report required)**
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

(For repair of hypoplastic left heart syndrome (eg, norwood type), via excision of coarctation of aorta, use 33619)

THORACIC AORTIC ANEURYSM

33860 Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension;
33861 with coronary reconstruction
33863 with aortic root replacement using composite prosthesis and coronary reconstruction

(For graft of ascending aorta, with cardiopulmonary bypass and valve replacement, with or without coronary implant or valve suspension; use 33860 or 33861 and 33405 or 33406)

33864 Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic annulus remodeling (eg, David procedure, Yacoub procedure)
(Do not report 33864 in conjunction with 32551, 33210, 33211, 33400, 33860, 33863)

33870 Transverse arch graft, with cardiopulmonary bypass
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. Open arterial exposure and associated closure of the arteriotomy sites (eg, 34812, 34820, 34833, 34834), introduction of guidewires and catheters (eg, 36140, 36200-36218), and extensive repair or replacement of an artery (eg, 35226, 35286) should be additionally reported. Transposition of subclavian artery to carotid, and carotid-carotid bypass performed in conjunction with endovascular repair of the descending thoracic aorta (eg, 33889, 33891) should be separately reported. The primary codes, 33880 and 33881, include placement of all distal extensions, if required, in the distal thoracic aorta, while proximal extensions, if needed, are reported separately. 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
(For radiological supervision and interpretation, use 75956 in conjunction with 33880)

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
(For radiological supervision and interpretation, use 75957 in conjunction with 33881)

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
(For radiological supervision and interpretation, use 75958 in conjunction with 33883)

(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)
(For radiological supervision and interpretation, use 75958 in conjunction with 33884)

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)
(For radiological supervision and interpretation, use 75959 in conjunction with 33886)

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

(For repair of other complex cardiac anomalies by construction or replacement of right or left ventricle to pulmonary artery conduit, use 33608)

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)
(Use 33924 in conjunction with 33470-33475, 33600-33619, 33684-33688, 33692-33697, 33735-33767, 33770-33781, 33786, 33920-33922)

33925 Repair of pulmonary artery arborization anomalies by unifocalization; without cardiopulmonary bypass **(Report required)**

33926 with cardiopulmonary bypass

(Do not report 33925, 33926 in conjunction with 33697)

HEART/LUNG TRANSPLANTATION

33935 Heart-lung transplant with recipient cardiectomy-pneumonectomy

33945 Heart transplant, with or without recipient cardiectomy

CARDIAC ASSIST

33960 Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial 24 hours

33961 each additional 24 hours
(List separately in addition to primary procedure)
(Use 33961 in conjunction with 33960)

(Do not report 33960, 33961 in conjunction with global neonatal and pediatric critical care codes 99293-99296)
(Do not report modifier –63 in conjunction with 33960, 33961)

(For insertion of cannula for prolonged extracorporeal circulation, use 36822)

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 ballon 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 **(Report required)**

33981 Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump **(Report required)**

33982 Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass **(Report required)**
33983 with cardiopulmonary bypass **(Report required)**

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 AORTIC ANEURYSM

Codes 34800-34826 represent a family of component procedures to report placement of an endovascular graft for abdominal aortic aneurysm repair. These codes describe open femoral or iliac artery exposure, device manipulation and deployment, and closure of the arteriotomy sites.

Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment, are not separately reportable. Introduction of guidewires and catheters should be reported separately (eg, 36200, 36245-36248, 36140). Extensive repair of an artery should be additionally reported (eg, 35226 or 35286).

For fluoroscopic guidance in conjunction with endovascular aneurysm repair, see code 75952 or 75953, as appropriate. Code 75952 includes angiography of the aorta and its branches for diagnostic imaging prior to deployment of the endovascular device (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 75953 includes the analogous services for placement of additional extension prostheses (not for routine components of modular devices).

Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair should be additionally reported (eg, aortography before deployment of endoprosthesis, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or native artery(s) outside the endoprosthesis target zone when done before or after deployment of graft).

34800 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis

34802 using modular bifurcated prosthesis (one docking limb)

34803 using modular bifurcated prosthesis (two docking limbs)

34804 using unibody bifurcated prosthesis

34805 using aorto-uniiliac or aorto-unifemoral prosthesis

34806 Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data
(List separately in addition to primary procedure)
(Do not report 34806 in conjunction with 93982)
(Use 34806 in conjunction with 33880, 33881, 33886, 34800-34805, 34825, 34900)

34808 Endovascular placement of iliac artery occlusion device
(List separately in addition to primary procedure)
(Use 34808 in conjunction with codes 34800, 34805, 34813, 34825, 34826)

(For radiological supervision and interpretation use 75952 in conjunction with 34800-34808)
(For open arterial exposure, report 34812, 34820, 34833, 34834 as appropriate, in addition to 34800-34808)

34812 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral
(For bilateral procedure, use modifier -50)

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)

(For femoral artery grafting, see 35521, 35533, 35539, 35540, 35551-35558, 35566, 35621, 35646, 35651-35661, 35666, 35700)

34820 Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral
(For bilateral procedure, use modifier -50)

34825 Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel

34826 each additional vessel
(List separately in addition to primary procedure)
(Use 34826 in conjunction with code 34825)
(For radiological supervision and interpretation, use 75953)

(Use 34825, 34826 in addition to 34800-34808, 34900 as appropriate)

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 aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral **(Report required)**
(Do not report 34833 in addition to 34820)
(For bilateral procedure, use modifier -50)

34834 Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis by arm incision, unilateral **(Report required)**
(For bilateral procedure, use modifier -50)

ENDOVASCULAR REPAIR OF ILIAC ANEURYSM

Code 34900 represents a procedure to report introduction, positioning, and deployment of an endovascular graft for treatment of aneurysm, psuedoaneurysm, or arteriovenous malformation or trauma of the iliac artery (common, hypogastric, external). All balloon angioplasty and/or stent deployments within the target treatment zone for the endoprosthesis, either before or after endograft deployment, are included in the work of 34900 and are not separately reportable. Open femoral or iliac artery exposure (eg, 34812, 34820), introduction of guidewires and catheters (eg, 36200, 36215-36218), and extensive repair or replacement of an artery (eg, 35206-35286) should be also reported.

For fluoroscopic guidance in conjunction with endovascular iliac aneurysm repair, see code 75954. Code 75954 includes angiography of the aorta and iliac arteries for diagnostic imaging prior to deployment of the endovascular device (including all routine components), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography to confirm appropriate position of the graft, detect endoleaks, and evaluate the status of the runoff vessels (eg, evaluation for dissection, stenosis, thrombosis, distal embolization, or iatrogenic injury).

Other interventional procedures performed at the time of endovascular aortic aneurysm repair should be additionally reported (eg, transluminal angioplasty outside the aneurysm target zone, arterial embolization, intravascular ultrasound).

34900 Endovascular graft replacement for repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) **(Report required)**
(For bilateral procedure, use modifier –50)
(For radiological supervision and interpretation, use 75954)

(For placement of extension prothesis during endovascular iliac artery repair, use 34825)

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.
(For direct repairs associated with occlusive disease only, see 35201-35286)
(For intracranial aneurysm, see 61700 et seq)
(For endovascular repair of abdominal aortic aneurysm, see 34800-34826)
(For endovascular repair of iliac artery aneurysm, see 34900)
(For thoracic aortic aneurysm, see 33860-33875)
(For endovascular repair of descending thoracic aorta, involving coverage of left subclavian artery origin, use 33880)

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, cartoid, subclavian artery, by neck incision

35002 for ruptured aneurysm, carotid, subclavian artery, by neck incision **(Report required)**

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, heptic, 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 occulsive 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 **(Report required)**
35184 extremities **(Report required)**
35188 Repair, acquired or traumatic arteriovenous fistula; head and neck
35189 thorax and abdomen **(Report required)**
35190 extremities

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

(For AV fistula repair, see 35180-35190)

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

(For coronary artery, see 33510-33536 and 33572)
(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 35483, 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 35485, 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

(For thromboendarterectomy of the superficial femoral artery, use 35302; of the popliteal artery, use 35303; of the tibioperoneal trunk, use 35304; of the tibial or peroneal artery, see 35305, 35306)

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

(For radiological supervision and interpretation, see 75962-75968 and 75978)

OPEN

35450 Transluminal balloon angioplasty, open; renal or other visceral artery
35452 aortic
35454 iliac
35456 femoral-popliteal
35458 brachiocephalic trunk or branches, each vessel
35459 tibioperoneal trunk and branches
35460 venous

PERCUTANEOUS

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.

35470 Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel
35471 renal or visceral artery
35472 aortic
35473 iliac
35474 femoral-popliteal
35475 brachiocephalic trunk or branches, each vessel
35476 venous
(For radiological supervision and interpretation, use 75978)

TRANSLUMINAL ATHERECTOMY

(For radiological supervision and interpretation, see 75992-75996)

OPEN

35480 Transluminal peripheral atherectomy, open; renal or other visceral artery
35481 aortic
35482 iliac
35483 femoral-popliteal
35484 brachiocephalic trunk or branches, each vessel
35485 tibioperoneal trunk and branches

PERCUTANEOUS

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.

35490 Transluminal peripheral atherectomy, percutaneous; renal or other visceral artery
35491 aortic
35492 iliac
35493 femoral-popliteal
35494 brachiocephalic trunk or branches, each vessel
35495 tibioperoneal trunk and branches

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)

(For harvest of more than one vein segment, see 35682, 35683)
(For endoscopic procedure, use 33508)

35501 Bypass graft, with vein; common carotid-ipsilateral internal carotid
35506 carotid-subclavian or subclavian-carotid

(For subclavian-carotid bypass with vein, use 35506)

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

(For bypass graft performed with synthetic graft, use 35621)

35522 axillary-brachial
35523 brachial-ulnar or -radial
(Do not report 35523 in conjunction with 35206, 35500, 35525, 36838)

(For bypass graft performed with synthetic conduit, use 37799)

35525 brachial-brachial
35526 aortosubclavian or carotid

(For bypass graft performed with synthetic graft, use 35626)

35531 aortoceliac or aortomesenteric
35533 axillary-femoral-femoral

(For bypass graft performed with synthetic graft, use 35654)

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)

(For bypass graft performed with synthetic graft, use 35637)

35538 aortobi-iliac
(Do not report 35538 in conjunction with 35537)

(For bypass graft performed with synthetic graft, use 35638)

35539 aortofemoral
(Do not report 35539 in conjunction with 35540)

(For bypass graft performed with synthetic graft, use 35647)

35540 aortobifemoral
(Do not report 35540 in conjunction with 35539)

(For bypass graft performed with synthetic graft, use 35646)
(For aortoiliac graft with vein, use 35537. For aortobi-iliac graft with vein, use 35538)
(For aortofemoral graft with vein use 35539. For aortobifemoral graft with vein, use 35540)

35548 aortoiliofemoral, unilateral

(For bypass graft performed with synthetic graft, use 37799)

35549 aortoiliofemoral, bilateral

(For bypass graft performed with synthetic graft, use 37799)

35551 aortofemoral-popliteal
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

(To report aortobifemoral bypass using synthetic conduit, and femoral-popliteal bypass with vein conduit in-situ, use 35646 and 35583. To report aorto(uni)femoral bypass with synthetic conduit, and femoral-popliteal bypass with vein conduit in-situ, use 35647 and 35583. To report aortofemoral bypass using vein conduit, and femoral-popliteal bypass with vein conduit in-situ, use 35539 and 35583)

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

OTHER THAN VEIN

(For arterial transposition and/or reimplantation, see 35691-35695)

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

(For open transcervical common carotid-common carotid bypass performed in conjunction with endovascular repair of descending thoracic aorta, use 33891)

(For open subclavian to carotid artery transposition performed in conjunction with endovascular thoracic aneurysm repair by neck incision, use 33889)

35612 subclavian-subclavian
35616 subclavian-axillary
35621 axillary-femoral
35623 axillary-popliteal or -tibial
35626 aortosubclavian or carotid
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)

(For aortoiliac graft constructed with conduit other than vein, use 35637. For aortobi-iliac graft with other than vein, use 35638)
(For open placement of aortobi-iliac prosthesis following unsuccessful endovascular repair, use 34831)

35642 carotid-vertebral

35645 subclavian-vertebral

35646 aortobifemoral

(For bypass graft performed with vein graft, use 35540)
(For open placement of aortobifemoral prosthesis following unsuccessful endovascular repair, use 34832)

35647 aortofemoral

(For bypass graft performed with vein graft, use 35539)

35650 axillary-axillary

35651 aortofemoral-popliteal

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.

(Do not report 35681-35683 in addition to each other.)

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)

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.

(For composite graft(s), see 35681-35683)

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

(For open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, use 33889)

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), with or without lysis of artery; carotid artery
35721 femoral artery
35741 popliteal artery
35761 other vessels
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

(For thrombectomy of hemodialysis graft or fistula, see 36831, 36833)

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. For thrombectomy with revision of any non-coronary arterial or venous graft, including those of the lower extremity, (other than hemodialysis graft or fistula), use 35876. For direct repair (other than for fistula) of a lower extremity blood vessel (with or without patch angioplasty), use 35226. For repair (other than for fistula) of a lower extremity blood vessel using a vein graft, use 35256.

35879 Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty
35881 with segmental vein interposition

(For revision of femoral anastomosis of synthetic arterial bypass graft, see 35883, 35884)
(For excision of infected graft, see 35901-35907 and appropriate revascularization code)

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.

(For injection procedures in conjunction with cardiac catheterization, see 93541-93545)

(For chemotherapy of malignant disease, see 96401-96549)

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)

(For imaging guidance, see 76942, 77002, 77012, 77021)
(For ultrasound guided compression repair of pseudoaneurysm, use 76936)

36005 Injection procedure for extremity venography (including introduction of needle or intracatheter)
(For radiological supervision and interpretation, see 75820, 75822)

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

(For insertion of flow directed catheter (eg, Swan-Ganz), use 93503)
(For venous catheterization for selective organ blood sampling, use 36500)

INTRA-ARTERIAL---INTRA-AORTIC

36100 Introduction of needle or intracatheter, carotid or vertebral artery
(For bilateral procedure, report 36100 with modifier -50)

36120 Introduction of needle or intracatheter; retrograde brachial artery
36140 extremity artery

(For insertion of arteriovenous cannula, see 36810-36821)

36147 Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluationof dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injections of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)
(If 36147 indicates the need for a therapeutic intervention requiring a second catheterization of the shunt, use 36148)
(Do not report 36147 in conjunction with 75791)

36148 additional access for therapeutic intervention
(List separately in addition to primary procedure)
(Use 36148 in conjunction with 36147)

36160 Introduction of needle or intracatheter, aortic, translumbar
36200 Introduction of catheter, aorta
36215 Selective catheter placement, arterial system; each first order thoracic or bracheocephalic branch, within a vascular family

(For catheter placement for coronary angiography, use 93508)

36216 initial second order thoracic or bracheocephalic branch, within a vascular family
36217 initial third order or more selective thoracic or bracheocephalic branch, within a vascular family
36218 additional second order, third order and beyond, thoracic or bracheocephalic 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)

(For angiography, see 75600-75790)
(For angioplasty, see 35470-35475)
(For transcatheter therapies, see 37200-37208, 61624, 61626)

When coronary artery, arterial conduit (eg, internal mammary, inferior epigastric or free radial artery) or venous bypass graft angiography is performed in conjunction with cardiac catheterization, see the appropriate cardiac catheterization code(s) (93501-93556) in the Medicine section. When coronary artery, arterial coronary conduit or venous bypass graft angiography is performed without concomitant left heart cardiac catheterization, use 93508. When internal mammary artery angiography only is performed without a concomitant left heart cardiac catheterization, use 36216 or 36217 as appropriate.

36245 Selective catheter placement, arterial system; each first order abdominal, pelvic or lower extremity artery branch, with 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
(Use 36248 in conjunction with 36246, 36247)

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 physician's skill, not to be used for routine venipuncture; femoral or jugular vein **(Report required)**
36405 scalp vein **(Report required)**
36406 other vein **(Report required)**
36420 Venipuncture, cutdown; younger than age 1 year
36425 age 1 or over **(Not to be used for routine venipuncture)** **(Report required)**
36430 Transfusion, blood or blood components
36440 Push transfusion, blood, 2 years or younger
36450 Exchange transfusion, blood; newborn
36455 other than newborn
36460 Transfusion, intrauterine, fetal
(For radiological supervision and interpretation, use 76941)

36468 Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk
36469 face

36470 Injection of sclerosing solution; single vein
36471 multiple veins, same leg
36475 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476 second and subsequent veins treated in a single extremity, each through separate access sites
(List separately in addition to primary procedure)
(Use 36476 in conjunction with 36475)

36481 Percutaneous portal vein catheterization by any method
(For radiological supervision and interpretation, see 75885, 75887)

36500 Venous catheterization for selective organ blood sampling
(For radiological supervision and interpretation, use 75893)

(For catheterization in superior or inferior vena cava, use 36010)

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
36515 with extracorporeal immunoadsorption and plasma reinfusion
36516 with extracorporeal 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.

(For refilling and maintenance of an implantable pump or reservoir for intravenous or intra-arterial drug delivery, use 96522)

INSERTION OF CENTRAL VENOUS ACCESS DEVICE

36555 Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age

(For peripherally inserted non-tunneled central venous catheter, younger than 5 years of age, use 36568)

36556 age 5 years or older

(For peripherally inserted non-tunneled central venous catheter, age 5 years or older, use 36569)

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

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

36560 Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; under 5 years of age

(For peripherally inserted central venous access device with subcutaneous port, younger than 5 years of age, use 36570)

36561 age 5 years or older

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

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; under 5 years of age

(For placement of centrally inserted non-tunneled central venous catheter, without subcutaneous port or pump, younger than 5 years of age, use 36555)

36569 age 5 years or older

(For placement of centrally inserted non-tunneled central venous catheter, without subcutaneous port or pump, age 5 years or older, use 36556)

36570 Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age

(For insertion of tunneled centrally inserted central venous access device with subcutaneous port, younger than 5 years of age, use 36560)

36571 age 5 years or older

(For insertion of tunneled centrally inserted central venous access device with subcutaneous port, age 5 years or older, use 36561)

REPAIR OF CENTRAL VENOUS ACCESS DEVICE

(For mechanical removal of pericatheter obstructive material, use 36595)
(For mechanical removal of intracatheter obstructive material, use 36596)

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

(For complete replacement of entire device through same venous access, use 36582 or 36583)

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

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)
(For radiological supervision and interpretation, use 75901)

(For venous catheterization, see 36010-36012)

36596 Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen
(Do not report 36596 in conjunction with 36593)
(For radiological supervision and interpretation, use 75902)

(For venous catheterization, see 36010-36012)

36597 Repositioning of previously placed central venous catheter under fluoroscopic guidance

(For fluoroscopic guidance, use 76000)

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)

(For complete diagnostic studies, see 75820, 75825, 75827)

ARTERIAL

36600 Arterial puncture, withdrawal of blood for diagnosis **(Report required)**
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)

(For arterial catheterization for occlusion therapy, see 75894)

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)
36822 Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)

(For maintenance of prolonged extracorporal circulation, see 33960, 33961)

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 collogen, thermoplastic graft)

(For procedures 36825, 36830 for direct arteriovenous anastomosis, use 36821)

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

(If imaging guidance is performed, use 76000)

36870 Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)
(Do not report 36870 in conjunction with code 36593)
(For radiological supervision and interpretation, see 36147, 75791)

(For catheterization, see 36147, 36148)

PORTAL DECOMPRESSION PROCEDURES

37140 Venous anastomosis, open; portocaval

(For peritoneal-venous shunt, use 49425)

37145 renoportal
37160 caval-mesenteric
37180 splenorenal, proximal
37181 splenorenal, distal (selective decompression of esophagogastric varices, any technique)

(For percutaneous procedure, use 37182)

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)
(For open procedure, use 37140)

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)

(For repair of arteriovenous aneurysm, use 36832)

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 37201, 75896, 75898).
For coronary mechanical thrombectomy, use 92973.
For mechanical thrombectomy for dialysis fistula, use 36870.

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

(Do not report 37184, 37185, 37816 in conjunction with 76000, 76001

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

(Do not report 37187, 37188 in conjunction with 76000, 76001)

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

37195 Thrombolysis, cerebral, by intravenous infusion

37200 Transcatheter biopsy
(For radiological supervision and interpretation, use 75970)

37201 Transcatheter therapy, infusion for thrombolysis other than coronary
(For radiological supervision and interpretation, use 75896)

37202 Transcatheter therapy, infusion other than for thrombolysis, any type (eg, spasmolytic, vasoconstrictive)
(For radiological supervision and interpretation, use 75896)

(For thromolysis of coronary vessels, see 92975, 92977)

37203 Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)
(For radiological supervision and interpretation, use 75961)

37204 Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck
(See also 61624, 61626)
(For radiological supervision and interpretation, use 75894)

(For uterine fibroid embolization [uterine artery embolization performed to treat uterine fibroids], use 37210)
(For obstetrical and gynecologic embolization procedures other than uterine fibroid embolization [eg, embolization to treat obstetrical or postpartum hemorrhage], use 37204)

37205 Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel
(For radiological supervision and interpretation, use 75960)

(For coronary stent placement, see 92980, 92981; intracranial, use 61635)

37206 each additional vessel
(List separately in addition to primary procedure)
(Use 37206 in conjunction with 37205)
(For radiological supervision and interpretation, use 75960)

(For transcatheter placement of intravascular cervical carotid artery stent(s), see 37215, 37216)

37207 Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; initial vessel

37208 each additional vessel
(List separately in addition to primary procedure)
(Use 37208 in conjunction with 37207)
(For radiological supervision and interpretation, use 75960)

(For catheterizations, see 36215-36248)
(For transcatheter placement of intracoronary stent(s), see 92980, 92981)

37209 Exchange of a previously placed intravascular catheter during thrombolytic therapy
(For radiological supervision and interpretation, use 75900)

37210 Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure
(37210 includes all catheterizations and intraprocedural imaging required for a UFE procedure to confirm the presence of previously known fibroids and to roadmap vascular anatomy to enable appropriate therapy)
(Do not report 37210 in conjunction with 36200, 36245-36248, 37204, 75894, 75898)

(For all other non-central nervous system (CNS) embolization procedures, use 37204)

37215 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; 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)

(Do not report 37215, 37216 in conjunction with 75671, 75680)

(For percutaneous transcatheter placement of intravascular stents other than coronary, carotid, or vertebral, see 37205, 37206)

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.

37250 Intrasvascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel
(List separately in addition to primary procedure)

37251 each additional vessel
(List separately in addition to primary procedure)
(Use 37251 in conjunction with 37250)
(For radiological supervision and interpretation see 75945, 75946)

(For catheterizations, see 36215-36248)
(For transcatheter therapies, see 37200-37208, 61624, 61626)

ENDOSCOPY

Surgical vascular endoscopy always includes diagnostic endoscopy.

37500 Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)
(For open procedure, use 37760)

37501 Unlisted vascular endoscopy procedure

LIGATION

(For phleborraphy and arteriorraphy, see 35201-35286)
(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

(For transcatheter permanent arterial occlusion or embolization, see 61624 -61626)
(For endovascular temporary arterial balloon occlusion, use 61623)
(For ligation treatment of intracranial aneurysm, use 61703)

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
37620 Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular,intravascular (umbrella device)
(For radiological supervision and interpretation, use 75940)

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)
(For ligation, division, and stripping of the greater saphenous vein, use 37722)

(For ligation, division, and stripping of the short saphenous vein, use 37718)

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

(For less than 10 incisions, use 37799)

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 **(Report required)**
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. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

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

INTRODUCTION

38200 Injection procedure for splenoportography
(For radiological supervision and interpretation, use 75810)

GENERAL

BONE MARROW OR STEM CELL SERVICES/PROCEDURES

38220 Bone marrow; aspiration only
38221 biopsy, needle or trocar
(For bone marrow biopsy interpretation, use 88305)
38230 Bone marrow harvesting for transplantation
38240 Bone marrow or blood-derived peripheral stem cell transplantation; allogenic
38241 autologous
38242 allogeneic donor lymphocyte infusions

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

(For injection for sentinel node identification, use 38792)

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)

(If imaging guidance is performed, see 76942, 77012, 77021)
(For fine needle aspiration, use 10021, 10022)

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)

(For percutaneous needle biopsy, retroperitoneal lymph node or mass, use 49180. For fine needle aspiration, use 10022)

38542 Dissection, deep jugular node(s)

(For radical cervical neck dissection, use 38720)

38550 Excision of cystic hygroma, 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

(When combined with prostatectomy, use 55812 or 55842)
(When combined with insertion of radioactive substance into prostate, use 55862)

38564 retroperitoneal (aortic and/or splenic)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.
To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

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

(For drainage of lymphocele to peritoneal cavity, use 49323)

38589 Unlisted laparoscopy procedure, lymphatic system

RADICAL LYMPHADENECTOMY (RADICAL RESECTION OF LYMPH NODES)

(For limited pelvic and retroperitoneal lymphadenectomies, see 38562, 38564)
(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, regional, including mediastinal and peritracheal nodes (List separately in addition to primary procedure)

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 Cloquet's 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)

(For excision and repair of lymphedematous skin and subcutaneous tissue, see 15004-15005, 15570-15650)

INTRODUCTION

38790 Injection procedure; lymphangiography
(For bilateral procedure, report 38790 with modifier 50)
(For radiological supervision and interpretation, see 75801-75807)

38792 for identification of sentinel node

(For excision of sentinel node, see 38500-38542)
(For nuclear medicine lymphatics and lymph gland imaging, use 78195)

38794 Cannulation, thoracic duct **(Report required)**
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

39200 Excision of mediastinal cyst
39220 Excision of mediastinal tumor

(For substernal thyroidectomy, use 60270)
(For thymectomy, use 60520)

ENDOSCOPY

39400 Mediastinoscopy, with or without biopsy

OTHER PROCEDURES

39499 Unlisted procedure, mediastinum

DIAPHRAGM

REPAIR

(For transabdominal repair of diaphragmatic (esophageal hiatal) hernia, see 43324, 43325)

39501 Repair, laceration of diaphragm, any approach
39502 Repair, paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, except neonatal
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)

39520 Repair, diaphragmatic hernia (esophageal hiatal); transthoracic
39530 combined, thoracoabdominal
39531 combined, thoracoabdominal, with dilation of stricture (with or without gastroplasty)
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

(For procedures on skin of lips, see 10060 et seq)

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

(For excision of mucous lesions, see 40810-40816)

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

(For reconstruction, see 13131 et seq)

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)

(To report rhinoplasty only for nasal deformity secondary to congenital cleft lip, see 30460, 30462)
(For repair of cleft lip, with cross lip pedicle flap (Abbe-Estlander type), use 40527)

40761 with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle

(For repair cleft palate, see 42200 et seq)
(For other reconstructive procedures, see 14060, 14061, 15120-15261, 15574, 15576, 15630)

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 **(Report required)**
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 **(Report required)**
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 **(Report required)**
40843 posterior, bilateral **(Report required)**
40844 entire arch **(Report required)**
40845 complex (including ridge extension, muscle repositioning)

(For skin grafts, see 15002 et seq)

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

(For frenoplasty, use 41520)

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

(For imaging guidance, see 76942, 77002, 77012, 77021)
(For stereotactic insertion of intracranial brachytherapy radiation sources, use 61770)
(For interstitial radioelement application, see 77776-77784)

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 **(Report required)**
(List 41114 in addition to code 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

41500 Fixation of tongue, mechanical, other than suture (eg, K-wire) **(Report required)**
41510 Suture of tongue to lip for micrognathia (Douglas type procedure)
41512 Tongue base suspension, permanent suture technique

(For fixation of tongue, mechanical, other than suture, use 41500)
(For suture of tongue to lip for micrognathia, use 41510)

41520 Frenoplasty (surgical revision of frenum, eg, with Z-plasty)

(For frenotomy, see 40806, 41010)

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 **(Report required)**
41821 Operculectomy, excision pericoronal tissues **(Report required)**
41822 Excision of fibrous tuberosities, dentoalveolar structures **(Report required)**
41823 Excision of osseous tuberosities, dentoalveolar structures **(Report required)**
41825 Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair **(Report required)**
41826 with simple repair **(Report required)**
41827 with complex repair

(For nonexcisional destruction, use 41850)

41828 Excision of hyperplastic alveolar mucosa, each quadrant (specify) **(Report required)**
41830 Alveolectomy, including curettage of osteitis or sequestrectomy
41850 Destruction of lesion (except excision), dentoalveolar structures **(Report required)**

OTHER PROCEDURES

41870 Periodontal mucosal grafting **(Report required)**

41872 Gingivoplasty, each quadrant (specify) **(Report required)**
41874 Alveoloplasty each quadrant (specify)

(For closure of lacerations, see 40830, 40831)
(For segmental osteotomy, use 21206)
(For reduction of fractures, see 21421-21490)

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 **(Report required)**

(For skin graft, see 14040-14302)
(For mucosal graft, use 40818)

42120 Resection of palate or extensive resection of lesion

(For reconstruction of palate with extraoral tissue, see 14040-14302,15050, 15120, 15240, 15576)

42140 Uvulectomy, excision of uvula
42145 Palatopharyngoplasty eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)

(For removal of exostosis of the bony palate, see 21031, 21032)

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

(For repair of oronasal fistula, use 30600)

42260 Repair of nasolabial fistula

(For repair of cleft lip, see 40700 et seq)

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

(If imaging guidance is performed for 42400, 42405, see 76942, 77002, 77012, 77021)

42400 Biopsy of salivary gland; needle
(For fine needle aspiration, see 10021, 10022)

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

(For suture or grafting of facial nerve, see 64864, 64865, 69740, 69745)

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); **(Report required)**
42508 with excision of one submandibular gland **(Report required)**
42509 with excision of both submandibular glands **(Report required)**
42510 with ligation of both submandibular (Wharton's) ducts

OTHER PROCEDURES

42550 Injection procedure for sialography
(For radiological supervision and interpretation, use 70390)

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
42802 hypopharynx
42804 nasopharynx, visible lesion, simple
42806 nasopharynx, survey for unknown primary lesion

(For laryngoscopic biopsy, see 31510, 31535, 31536)

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

(For closure with other flap(s), use appropriate number for flap(s))
(When combined with radical neck dissection, use also 38720).

42860 Excision of tonsil tags
42870 Excision or destruction lingual tonsil, any method (separate procedure)

(For resection of the nasopharynx (eg, juvenile angiofibroma) by bicoronal and/or transzygomatic approach, see 61586 and 61600)

42890 Limited pharyngectomy

42892 Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls

(When combined with radical neck dissection, use also 38720)

42894 Resection of pharyngeal wall requiring closure with myocutaneous or fasciocutaneous flap or free muscle, skin, or fascial flap with microvascular anastamosis

(When combined with radical neck dissection, use also 38720)
(For limited pharyngectomy with radical neck dissection, use 38720 with 42890)
(For flap used for reconstruction, see 15732, 15734, 15756, 15757, 15758)

REPAIR

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

(For pharyngeal flap, use 42225)

42953 Pharyngoesophageal repair

(For closure with myocutaneous or other flap, use appropriate number in addition)

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

(For esophageal intubation with laparotomy, use 43510)

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

EXCISION

(For gastrointestinal reconstruction for previous esophagectomy, see 43360, 43361)

43100 Excision of lesion, esophagus, with primary repair; cervical approach

43101 thoracic or abdominal approach

(For wide excision of malignant lesion of cervical esophagus, with total laryngectomy without radical neck dissection, see 43107, 43116, 43124, and 31360)

(For wide excision of malignant lesion of cervical esophagus, with total laryngectomy with radical neck dissection, see 43107, 43116, 43124, and 31365)

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

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

(For free jejunal graft with mircovascular anastomosis performed by another physician, use 43496)

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)

(For total esophagectomy with gastropharyngostomy, see 43107, 43124)
(For esophagogastrectomy (lower third) and vagotomy, use 43122)

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

For endoscopic procedures, code appropriate endoscopy of each anatomic site examined. Surgical endoscopy always includes diagnostic endoscopy.
(Do not report 43232, 43237, 43238, 43242 in conjunction with 76942, 76975)

43200 Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

43201 with directed submucosal injection(s), any substance

(For injection sclerosis of esophageal varcies, use 43204)

43202 with biopsy, single or multiple

43204 with injection sclerosis of esophageal varices

43205 with band ligation of esophageal varcies

43215 with removal of foreign body
(For radiological supervision and interpretation, use 74235)

43216 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery

43217 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

43219 with insertion of plastic tube or stent

43220 with balloon dilation (less than 30 mm diameter)

(If imaging guidance is performed, use 74360)
(For endoscopic dilation with balloon 30 mm diameter or larger, use 43458)
(For dilation without visualization, see 43450-43453)
(For diagnostic fiberoptic esophagogastroscopy, use 43200, 43235)
(For fiberoptic esophagogastroscopy with biopsy or collection of specimen, use 43200, 43202, 43235, 43239)
(For fiberoptic esophagogastroscopy with removal of polyp(s), use 43217, 43251)
(For fiberoptic esophagogastroscopy with removal of foreign body, use 43215, 43247)

43226 with insertion of guide wire followed by dilation over guide wire
(For radiological supervision and interpretation, use 74360)

43227 with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)

43228 with ablation of tumor(s), polyp(s),or other lesions(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
(For esophagoscopic photodynamic therapy, report 43228 in addition to 96570, 96571 as appropriate)

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)

43234 Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)

43235 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

43236 with directed submucosal injection(s), any substance

(For injection sclerosis of esophageal and/or gastric varices, use 43243)

43237 with endoscopic ultrasound examination limited to the esophagus
43238 with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)
43239 with biopsy, single or multiple
43240 with transmural drainage of pseudocyst
43241 with transendoscopic intraluminal tube or catheter placement
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 and/or jejunum as appropriate)

(For transendoscopic fine needle aspiration/biopsy limited to esophagus, use 43238)

43243 with injection sclerosis of esophageal and/or gastric varices
43244 with band ligation of esophageal and/or gastric varices
43245 with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie) (Do not report 43245 in conjunction with 43256)

43246 with directed placement of percutaneous gastrostomy tube

(For nonendoscopic percutaneous placement of gastrostomy tube, see 49440)

43247 with removal of foreign body
(For radiological supervision and interpretation, use 74235)

43248 with insertion of guide wire followed by dilation of esophagus over guide wire
43249 with balloon dilation of esophagus (less than 30 mm diameter)
43250 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
43251 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43255 with control of bleeding, any method
43256 with transendoscopic stent placement (includes predilation)
43258 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

(For injection sclerosis of esophageal varices, use 43204 or 43243)

43259 with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate
(Do not report 43259 in conjunction with 76975)

(For radiological supervision and interpretation for 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272 see 74328, 74329, 74330)

43260 Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
(For radiological supervision and interpretation, see 74328, 74329, 74330)

43261 with biopsy, single or multiple
43262 with sphincterotomy/papillotomy

43263 with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)

(For 43264, 43265, 43267, 43268, 43269, 43271, when done with sphincterotomy, also use 43262)

43264 with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts

43265 with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method

43267 with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube

43268 with endoscopic retrogade insertion of tube or sent into bile or pancreatic duct

43269 with endoscopic retrograde removal of foreign body and/or change of tube or stent

43271 with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)

43272 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

43273 Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s)
(List separately in addition to code(s) for primary procedure)
(Use 43273 in conjunction with 43260, 43261, 43263-43265, 43267-43272)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.
To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

43279 Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed
(Do not report 43279 in conjunction with 43280)
(For open approach, see 43330, 43331)

43280 Laparascopy, 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
(For transthoracic paraesophageal hernia repair, use 39520. For transabdominal paraesophageal hernia repair, use 39502)
(Do not report 43281, 43282 in conjunction with 43280, 43450, 43453, 43456, 43458, 49568)

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 **(Report required)**
43314 with repair of congenital tracheoesophageal fistula **(Report required)**

(Do not report modifier –63 in conjunction with 43313, 43314)

43320 Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach
43324 Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)
(For laparoscopic procedure, use 43280)

43325 Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)
(For cricopharyngeal myotomy, see 43030)

43326 with gastroplasty (eg, Collis)
43330 Esophagomyotomy (Heller type); abdominal approach
43331 thoracic approach

(For thoracoscopic esophagomyotomy, use 32665)

43340 Esophagojejunostomy (without total gastrectomy); abdominal approach
43341 thoracic approach
43350 Esophagostomy, fistulization of esophagus, external; abdominal approach
43351 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
43401 Transection of esophagus with repair, for esophageal varices
43405 Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation
43410 Suture of esophageal wound or injury; cervical approach **(Report required)**
43415 transthoracic or transabdominal approach
43420 Closure of esophagostomy or fistula; cervical approach
43425 transthoracic or transabdominal approach

(For repair of esophageal hiatal hernia, see 39520 et seq)

MANIPULATION

(For associated esophagogram, use 74220)
(For radiological supervision and interpretation for 43450, 43453, 43456, 43458 use 74360)

43450 Dilation of esophagus; by unguided sound or bougie, single or multiple passes
43453 over guide wire

(For dilation with direct visualization, use 43220)
(For dilation of esophagus, by balloon or dilator, see 43220, 43458, and 74360)

43456 by balloon or dilator, retrograde
43458 with balloon (30 mm diameter or larger) for achalasia

(For dilation with balloon less than 30 mm diameter, see 43220)

43460 Esophagogastric tamponade, with balloon (Sengstaaken type)

(For removal of esophageal foreign body by balloon catheter, see 43215, 43247, 74235)

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

43600 Biopsy of stomach; by capsule, tube, peroral (one or more specimens)
43605 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 **(Report required)**

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

(For pyloroplasty, use 43800)
(For vagotomy, see 64752-64760)

43641 parietal cell (highly selective)

(For upper gastrointestinal endoscopy, see 43234-43259)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.
To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.
(For upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum, see 43235-43259)

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)
(For greater than 150 cm, use 43645)
(For open procedure, use 43846)

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

To report percutaneous gastrostomy tube insertion, use 43246)

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)

(For percutaneous placement of gastrostomy tube, use 49440)
(For enteric tube placement, see 44500, 74340)

43760 Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance

(To report fluoroscopically guided replacement of gastrostomy tube, use 49450)
(For endoscopic placement of gastrostomy tube, use 43246)

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)

(If imaging guidance is performed, use 76000)
(For placement of a long gastrointestinal tube into the duodenum, use 44500)
(For endoscopic conversion of a gastrostomy tube to jejunostomy tube, use 44373)

BARIATRIC SURGERY

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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.
To report a diagnostic laparoscopy (separate procedure), use 49320.
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

(For removal and replacement of both gastric band and subcutaneous port components, use 43659)

OTHER PROCEDURES

43800 Pyloroplasty

(For pyloroplasty and vagotomy, use 43640)

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)

(For change of gastrostomy tube, use 43760)

43832 with construction of gastric tube (eg, Janeway procedure)

(For percutaneous endoscopic gastrostomy, use 43246)

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) **(Report required)**
(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
(For laparoscopic procedure, use 43644)

(For greater than 150 cm, use 43847)

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)

(For laparoscopic adjustable gastric restrictive procedures, see 43770-43774)
(For gastric restrictive port procedures, see 43886-43888)

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)

(For laparoscopic removal of both gastric band and subcutaneous port components, use 43774)
(For removal and replacement of both gastric band and subcutaneous port components, use 43659)

43999 Unlisted procedure, stomach

INTESTINES (EXCEPT RECTUM)

INCISION

44005 Enterolysis (freeing of intestinal adhesion) (separate procedure)
(Do not report 44005 in addition to 45136)
(For laparoscopic approach, use 44180)

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

(For exteriorization of intestine (Mikulicz resection with crushing of spur), see 44602-44605)

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 cadavor donor
44136 from living donor
44137 Removal of transplanted intestinal allograft, complete **(Report required)**

(For partial removal of transplant allograft, see 44120, 44121, 44140)

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
(For laparoscopic procedure, use 44204)

44143 with end colostomy and closure of distal segment (Hartmann type procedure)
(For laparoscopic procedure, use 44206)

44144 with resection, with colostomy or ileostomy and creation of mucofistula
44145 with coloproctostomy (low pelvic anastomosis)
(For laparoscopic procedure, use 44207)
44146 with coloproctostomy (low pelvic anastomosis), with colostomy
(For laparoscopic procedure, use 44208)

44147 abdominal and transanal approach
44150 Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy
(For laparoscopic procedure, use 44210)

44151 with continent ileostomy
44155 Colectomy, total, abdominal, with proctectomy; with ileostomy
(For laparoscopic procedure, use 44212)

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
(For laparoscopic procedure, use 44211)

44160 Colectomy, partial, with removal of terminal ileum with ileocolostomy

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

INCISION

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

(For laparoscopy with salpingolysis, ovariolysis, use 58660)

ENTEROSTOMY-EXTERNAL FISTULIZATION OF INTESTINES

44186 Laparoscopy, surgical; jejunostomy (eg, for decompression or feeding)
44187 ileostomy or jejunostomy, non-tube
(For open procedure, use 44310)

44188 Laparoscopy, surgical, colostomy or skin level cecostomy
(Do not report 44188 in conjunction with 44970)
(For open procedure, use 44320)

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)
(For open procedure, see 44120, 44121)

44204 colectomy, partial, with anastomosis
(For open procedure, use 44140)

44205 colectomy, partial, with removal of terminal ileum with ileocolostomy
(For open procedure, use 44160)

44206 colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)
(For open procedure, use 44143)

44207 colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)
(For open procedure, use 44145)

44208 colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy
(For open procedure, use 44146)

44210 colectomy, total, abdominal, without protectomy, with ileostomy or ileoproctostomy
(For open procedure, use 44150)

44211 colectomy, total, abdominal, with protectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed
(For open procedure, see 44157, 44158)

44212 colectomy, total, abdominal, with proctectomy, with ileostomy
(For open procedure, use 44155)

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)
(For open procedure, use 44139)

REPAIR

44227 Laparoscopy, surgical, closure of enterostomy, large or small intestine, with resection and anastomosis
(For open procedure, see 44625, 44626)

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)

(For percutaneous placement of duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy [or other colonic] tube including fluoroscopic imaging guidance, see 49441-49442)

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)

(For fiberoptic evaluation, use 44385)

44320 Colostomy or skin level cecostomy;
(For laparoscopic procedure, use 44188)
(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.
(For upper gastrointestinal endoscopy, see 43234-43258)

44360 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44361 with biopsy, single or multiple
44363 with removal of foreign body
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

(For fiberoptic jejunostomy through stoma, use 43235)

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 transendonscopic stent placement (includes predilation)
44380 Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44382 with biopsy, single or multiple
44383 with transendoscopic stent placement (includes predilation)
44385 Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44386 with biopsy, single or multiple
44388 Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44389 with biopsy, single or multiple
44390 with removal of foreign body
44391 with control of bleeding,(eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) **(Report required)**
44392 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery

44393 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44394 with removal of tumor(s), polyp(s), or other lesion(s) by snare techniques

(For colonoscopy per rectum, see 45330-45385)

44397 with transendoscopic stent placement (includes predilation)

INTRODUCTION

44500 Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)
(For radiological supervision and interpretation, see 74340)

(For naso- or oro-gastric tube placement, use 43752)

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 colorecta anastomosis (eg, closure of Hartmann type procedure)
(For laparoscopic procedure, use 44227)

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

(For closure of renocolic fistula, see 50525, 50526)
(For closure of gastrocolic fistula, use 43880)
(For closure of rectovesical fistula, see 45800, 45805)

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, intestine

(For unlisted laparoscopic procedure, intestine except rectum, use 44238)

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)

(With intestine resection, see 44120 or 44140 et seq)

SUTURE

44850 Suture of mesentery (separate procedure)

(For reduction and repair of internal hernia, use 44050)

OTHER PROCEDURES

44899 Unlisted procedure, Meckel's diverticulum and the mesentery

APPENDIX

INCISION

44900 Incision and drainage of appendiceal abscess; open
44901 percutaneous
(For radiological supervision and interpretation, use 75989)

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. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

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)

(For endoscopic biopsy, use 45305)

45108 Anorectal myomectomy
45110 Proctectomy; complete, combined abdominoperineal, with colostomy
(For laparoscopic procedure, use 45395)

45111 partial resection of rectum, transabdominal approach
45112 Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis)

(For colo-anal anastomosis with colonic reservoir or pouch, use 45119)

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 Protectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed
(For laparoscopic procedure, use 45397)

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, transacral 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)
(For radiological supervision and interpretation, use 74360)

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, with or without collection of specimen(s) by brushing or washing (separate procedure)

45331 with biopsy, single or multiple

45332 with removal of foreign body

45333 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery

45334 with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)

45335 with directed submucosal injection(s), any substance
45337 with decompression of volvulus, any method
45338 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45339 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45340 with dilation by balloon, 1 or more strictures
(Do not report 45340 in conjunction with 45345)

45341 with endoscopic ultrasound examination
45342 with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)

(Do not report 45341, 45342 in conjunction with 76942,76975)

(For transrectal ultrasound utilizing rigid probe device, use 76872)

45345 with transendoscopic stent placement (includes predilation)
45355 Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple

(For fiberoptic colonoscopy beyond 25cm to splenic flexure, see 45330-45345)

45378 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379 with removal of foreign body
45380 with biopsy, single or multiple
45381 with directed submucosal injection(s), any substance
45382 with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45383 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

(For small bowel and stomal endoscopy, see 44360-44393)

45386 with dilation by balloon, 1 or more strictures
(Do not report 45386 in conjunction with 45387)

45387 with transendoscopic stent placement (includes predilation)
45391 with endoscopic ultrasound examination
45392 with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)

(Do not report 45391, 45392 in conjunction with 45330, 45341, 45342, 45378, 76872)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

EXCISION

45395 Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy
(For open procedure, use 45110)

45397 proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy, when performed
(For open procedure, use 45119)

REPAIR

45400 Laparoscopy, surgical; proctopexy (for prolapse)
(For open procedure, use 45540, 45541)

45402 proctopexy (for prolapse), with sigmoid resection
(For open procedure, use 45550)

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
(For laparoscopic procedure, use 45400)

45541 perineal approach
45550 with sigmoid resection, abdominal approach
(For laparoscopic procedure, use 45402)

45560 Repair of rectocele (separate procedure)

(For repair of rectocele with posterior colporrhapy, use 57250)

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

(For rectovaginal fistula closure, see 57300-57308)

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

45999 Unlisted procedure, rectum

(For unlisted laparoscopic procedure, rectum, use 45499)

ANUS

INCISION

(For subcutaneous fistulotomy, use 46270)

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)

(For anoplasty, see 46700-46705)

46080 Sphincterotomy, anal, division of sphincter (separate procedure)
46083 Incision of thrombosed hemorrhoid, external

EXCISION

46200 Fissurectomy, including sphincterotomy, when performed
46220 Excision of single external papilla or tag, anus
46221 Hemorrhoidectomy, internal, by rubber band ligation(s)
46230 Excision of multiple external papillae or tags, anus
46250 Hemorrhoidectomy, external, 2 or more columns/groups
46255 Hemorrhoidectomy, internal and external, simple column/group;
46257 with fissurectomy
46258 with fistulectomy, including fissurectomt, when performed
46260 Hemorrhoidectomy, internal and external, 2 or more columns/groups;
46261 with fissurectomy
46262 with fistulectomy, including fissurectomy, when performed

(For injection of hemorrhoids, use 46500; for destruction use46930; for ligation, see 46945, 46946; for hemorrhoidopexy, use 46947)

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
46320 Excision of thrombosed hemorrhoid, external

INTRODUCTION

46500 Injection of sclerosing solution, hemorrhoids

(For excision of hemorrhoids, see 46250-46262; for destruction use 46930; for ligation, see 46945, 46946; for hemorrhoidopexy, use 46947)

46505 Chemodenervation of internal anal sphincter

(For chemodenervation of other muscles, see 64612-64614, 64640)
(Report the specific service in conjunction with the specific substance(s) or drug(s) provided)

ENDOSCOPY

(Surgical endoscopy always includes diagnostic endoscopy)

46600 Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
(Do not report 46600 in addition to 46020)
46604 with dilation, (eg, balloon, guide wire, bougie)
46606 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

(Do not report modifier 63 in conjunction with 46705, 46715, 46716, 46730, 46735, 46740, 46742, 46744)

46700 Anoplasty, plastic operation for stricture; adult
46705 infant

(For simple incision of anal septum, see 46070)

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 an operineal 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 **(Report required)**
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 **(Report required)**
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 **(Report required)**
46760 Sphincteroplasty, anal, for incontinence, adult; muscle transplant
46761 levator muscle imbrication(Park posterior anal repair)
46762 implantation artificial sphincter

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)

(For incision of external thrombosed hemorrhoid(s), use 46083; for destruction of internal hemorrhoid(s) by thermal energy, use 46930; for destruction of hemorrhoid(s) by cryosurgery, use 46999; for excision of hemorrhoid(s), see 46250-46262, 46320; for injection, use 46500; for ligation, see 46221, 46945, 46946; for hemorrhoidopexy, use 46947)

46940 Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); initial
46942 subsequent

SUTURE

46945 Ligation of internal hemorrhoids; single procedure
46946 multiple procedures
46947 Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling

(For excision of hemorrhoids, see 46250-46262; for injection, use 46500; for destruction, see 46930)

OTHER PROCEDURES

46999 Unlisted procedure, anus

LIVER

INCISION

47000 Biopsy of liver, needle; percutaneous
(If imaging guidance is performed, see 76942, 77002, 77012, 77021)

47001 when done for indicated purpose at time of other major procedure
(List separately in addition to primary procedure)

(If imaging guidance is performed, see 76942, 77002)
(For fine needle aspiration in conjunction with 47000, 47001, see 10021, 10022)

47010 Hepatotomy; for open drainage of abscess or cyst, one or two stages
47011 for percutaneous drainage of abscess or cyst, one or two stages
(For radiological supervision and interpretation, use 75989)

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. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

47370 Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency
(For imaging guidance, use 76490)

47371 cryosurgical
(For imaging guidance, use 76490)

47379 Unlisted laparoscopic procedure, liver

OTHER PROCEDURES

47380 Ablation, open, of 1 or more liver tumor(s); radiofrequency
(For imaging guidance, use 76490)

47381 cryosurgical
(For imaging guidance, use 76490)

47382 Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency
(For imaging guidance and monitoring, see 76490, 77013, 77022)

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 with exploration, drainage, or removal of calculus (separate procedure)
47490 Percutaneous cholecystostomy
(For radiological supervision and interpretation, use 75989)

INTRODUCTION

47500 Injection procedure for percutaneous transhepatic cholangiography
(For radiological supervision and interpretation, use 74320)

47505 Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube)
(For radiological supervision and interpretation, use 74305)

47510 Introduction of percutaneous transhepatic catheter for biliary drainage
(For radiological supervision and interpretation, use 75980)

47511 Introduction of percutaneous transhepatic stent for internal and external biliary drainage
(For radiological supervision and interpretation, use 75982)

47525 Change of percutaneous biliary drainage catheter
(For radiological supervision and interpretation, use 75984)

47530 Revision and/or reinsertion of transhepatic tube
(For radiological supervision and interpretation, use 75984)

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 or without collection of specimen(s) by brushing and/or washing (separate procedure)
47553 with biopsy, single or multiple ttt
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

(For ERCP, see 43260-43272, 74363)
(If imaging guidance is performed, see 74363, 75982)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

47560 Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy
47561 with guided transhepatic cholangiography with biopsy
47562 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
(For laparoscopic approach, see 47562-47564)

47610 Cholecystectomy with exploration of common duct;

(For cholecystectomy with exploration of common duct with biliary endoscopy, use 47610 with 47550)

47612 with choledochoenterostomy
47620 with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography
47630 Biliary duct stone extraction, percutaneous via T-tube tract, basket or snare (eg, Burhenne technique)
(For radiological supervision and interpretation, use 74327)

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

(For anastomosis, see 47760-47800)

47715 Excision of choledochal cyst

REPAIR

47720 Cholecystoenterostomy; direct
(For laparoscopic approach, use 47570)

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

(For peroral pancreatic endoscopic procedures, see 43260-43272)

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
(For radiological supervision and interpretation, see 76942, 77002, 77012, 77021)

(For fine needle aspiration, use 10022)

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 **(Report required)**
48155 Pancreatectomy, total
48160 Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells **(Report required)**

INTRODUCTION

48400 Injection procedure for intraoperative pancreatography
(List separately in addition to primary procedure)
(For radiological supervision and interpretation, see 74300-74305)

REPAIR

48500 Marsupialization of pancreatic cyst
48510 External drainage, pseudocyst of pancreas; open
48511 percutaneous
(For radiological supervision and interpretation, use 75989)

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

(To report wound exploration due to penetrating trauma without laparotomy for 49000, 49010, use 20102)
(For radiological supervision and interpretation for 49021, 49041, 49061, use 75989)

49000 Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)
49002 Reopening of recent laparotomy

(To report re-exploration of hepatic wound for removal of packing, use 47362)

49010 Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)
49020 Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; open

(For appendiceal abscess, use 44900)

49021 percutaneous
49040 Drainage of subdiaphragmatic or subphrenic abscess; open
49041 percutaneous
49060 Drainage of retroperitoneal abscess; open
49061 percutaneous

(For laparoscopic drainage, use 49323)

49062 Drainage of extraperitoneal lymphocele to peritoneal cavity, open
49080 Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial
49081 subsequent

(If imaging guidance is performed, see 76942, 77012)

EXCISION, DESTRUCTION

(For lysis of intestinal adhesions, use 44005)

49180 Biopsy, abdominal or retroperitoneal mass, percutaneous needle

(If imaging guidance is performed, see 76942, 77002, 77012, 77021)
(For fine needle aspiration, use 10021 or 10022)

(For resection of recurrent ovarian, tubal, primary peritoneal, or uterine malignancy, see 58957, 58958)
(For open cryoablation of renal tumor, use 50250)

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)
(For colectomy, use 44140 in conjunction with 49203-49205)
(For small bowel resection, use 44120 in conjunction with 49203-49205)
(For vena caval resection with reconstruction, use 49203-49205 in conjunction with 37799)
(For partial or total nephrectomy, use 50220 or 50240 in conjunction with 49203-49205)
(For resection of recurrent ovarian, tubal, primary peritoneal or uterine malignancy, see 58957, 58958)
(For cryoablation of renal tumors, see 50250, 50593)

49215 Excision of presacral or sacrococcygeal tumor
(Do not report modifier 63 in conjunction with 49215)

49220 Staging laparotomy for Hodgkin's disease or lymphoma (includes splenectomy, needle or open biopsies of both liver lobes, possibly also removal of abdominal nodes, abdominal node and/or bone marrow biopsies, ovarian repositioning) **(Report required)**
49250 Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)
49255 Omentectomy, epiploectomy, resection of omentum (separate procedure)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy), (separate procedure), use 49320.

For laparoscopic fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface use 58662.

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

(For percutaneous or open drainage, see 49060, 49061)

49324 with insertion of intraperitoneal cannula or catheter, permanent
(For subcutaneous extension of intraperitoneal catheter with remote chest exit site, use 49435 in conjunction with 49324)

(For open insertion of permanent intraperitoneal cannula or catheter, use 49421)

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)

49329 Unlisted laparoscopy procedure, abdomen, peritoneum and omentum

INTRODUCTION, REVISION AND/OR REMOVAL

49400 Injection of air or contrast into peritoneal cavity (separate procedure)
(For radiological supervision and interpretation, use 74190)

49402 Removal of peritoneal foreign body from peritoneal cavity

(For lysis of intestinal adhesions, use 44005)

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

49419 Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (ie, totally implantable)

(For removal, use 49422)

49420 Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary

49421 permanent
(For subcutaneous extension of intraperitoneal catheter with remote chest exit site, use 49435 in conjunction with 49421)

(For laparoscopic insertion of permanent intraperitoneal cannula or catheter, use 49324)

49422 Removal of permanent intraperitoneal cannula or catheter

(For removal of a temporary catheter/cannula, use appropriate E/M code)

49423 Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)
(For radiological supervision and interpretation, use 75984)

49424 Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure)
(For radiological supervision and interpretation, use 76080)

49425 Insertion of peritoneal-venous shunt

49426 Revision of peritoneal-venous shunt

(For shunt patency test, use 78291)

49427 Injection procedure (eg, contrast media) for evaluation of previously placed peritoneal-venous shunt
(For radiological supervision and interpretation, see 75809, 78291)

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

(For conversion of gastrostomy tube to gastro-jejunostomy tube, use 49446)

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.

The excision/repair of strangulated organs or structures such as testicle(s), intestine, ovaries are reported by using the appropriate code for the excision/repair (eg, 44120, 54520, and 58940) in addition to the appropriate code for the repair of the strangulated hernia.

(For reduction and repair of intra-abdominal hernia, see 44050)
(For debridement of abdominal wall, see 11042, 11043)

(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

(Postconception age equals gestational age at birth plus age of infant in weeks at the time of the hernia repair. Initial inguinal hernia repairs that are performed on preterm infants who are older than 50 weeks post-conception age and younger than 6 months of age at the time of surgery, should be reported using codes 49495, 49496)

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

(Postconceptual age equals gestational age at birth plus age in weeks at the time of the hernia repair. Initial inguinal hernia repairs that are performed on preterm infants who are younger than or up to 50 weeks postconceptual age but younger than 6 months of age since birth , should be reported using codes 49491, 49492. Inguinal hernia repairs on infants age 6 months to younger than 5 years should be reported using codes 49500-49501)

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

(For inguinal hernia repair, with simple orchiectomy, see 49505 or 49507 and 54520)

(For inguinal hernia repair, with excision of hydrocele or spermatocele, see 49505 or 49507 and 54840 or 55040)

49520 Repair recurrent inguinal hernia, any age; reducible

49521 incarcerated or strangulated

49525 Repair inguinal hernia, sliding, any age

(For incarcerated or strangulated inguinal hernia repair, see 49496, 49501, 49507, 49521)

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

(For diaphragmatic or hiatal hernia repair, see 39502-39541)
(For surgical repair of omentum, use 49999)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy), (separate procedure), use 49320.

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

(For suture of ruptured diaphragm, see 39540, 39541)
(For debridement of abdominal wall, see 11042, 11043)

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

(For retroperitoneal exploration, abscess, tumor, or cyst, see 49010, 49060, 49203-49205)

50010 Renal exploration, not necessitating other specific procedures

(For laparoscopic ablation of renal mass lesion(s), use 50542)

50020 Drainage of perirenal or renal abscess; open
50021 percutaneous
(For radiological supervision and interpretation, use 75989)

50040 Nephrostomy, nephrotomy with drainage
50045 Nephrotomy, with exploration

(For renal endoscopy performed with nephrotomy, see 50570-50580)

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

(For flourocopic guidance, see 76000-76001)
(For establishment of nephrostomy without nephrostolithotomy, see 50040, 50395 or 52334)

50100 Transection or repositioning of aberrant renal vessels (separate procedure)
50120 Pyelotomy; with exploration

(For renal endoscopy performed in conjunction with this procedure, see 50570-50580)

50125 with drainage, pyelostomy
50130 with removal of calculus (pyelolithotomy, pelviolithotomy, including coagulum pyelolithotomy)
50135 complicated (eg, secondary operation, congenital kidney abnormality)

(For supply of anticarcinogenic agents, use appropriate codes in addition to code for primary procedure)

EXCISION

(For excision of retroperitoneal tumor or cyst, see 49203-49205)
(For laparoscopic ablation of renal mass lesion(s), use 50542)

50200 Renal biopsy; percutaneous, by trocar or needle
(For radiological supervision and interpretation, see 76942, 77002, 77012, 77021)

(For fine needle aspiration, use 10022)

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

(When vena caval resection with reconstruction is necessary use 37799)

50234 Nephrectomy with total ureterectomy and bladder cuff; through same incision
50236 through separate incision
50240 Nephrectomy, partial

(For laparoscopic partial nephrectomy, use 50543)

50250 Ablation, open, one or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound, if performed

(For laparoscopic ablation of renal mass lesions, use 50542)
(For cryoablation of renal tumors, use 50593)

50280 Excision or unroofing of cyst(s)of kidney

(For laparoscopic ablation of renal cysts, use 50541)

50290 Excision of perinephric cyst

RENAL TRANSPLANTATION

(For dialysis, see 90935-90999)
(For laparoscopy donor nephrectomy, use 50547)
(For laparoscopic drainage of lymphocele to peritoneal cavity, use 49323)

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

(For bilateral procedure for 50382, 50384, 50387, use modifier -50)

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

(Do not report 50382, 50384 in conjunction with 50395)
(For removal of an internally dwelling ureteral stent via a transurethral approach, use 50386)

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

(For removal and replacement of externally accessible ureteral stent via ureterostomy or ilieal conduit, use 50688)
(For removal without replacement of an externally accessible ureteral stent not requiring fluoroscopic guidance, see E/M services codes)

50389 Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent)

(Removal of nephrostomy tube not requiring fluoroscopic guidance is considered inherent to E/M services. Report the appropriate level of E/M service provided)

OTHER INTRODUCTION PROCEDURES

50390 Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous
(For radiological supervision and interpretation, see 74425, 74470, 76942, 77002, 77012, 77021)

50391 Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent)

50392 Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous
(For radiological supervision and interpretation, see 74475, 76942, 77012)

50393 Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous
(For radiological supervision and interpretation, see 74480, 76942, 77002, 77012)

50394 Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter
(For radiological supervision and interpretation, use 74425)

50395 Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous
(For radiological supervision and interpretation, see 74475, 74480, 74485)

(For nephrostolithotomy, see 50080, 50081)
(For retrograde percutaneous nephrostomy, use 52334)
(For endoscopic surgery, see 50551-50561)

50396 Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter
(For radiological supervision and interpretation, see 74425, 74475, 74480)

50398 Change of nephrostomy or pyelostomy tube
(For radiological supervision and interpretation, use 75984)

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)

(For laparoscopic approach, use 50544)

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. To report a diagnostic laparoscopy (peritoneoscopy), (separate procedure), use 49320.

50541 Laparoscopy, surgical; ablation of renal cysts
50542 ablation of renal mass lesion(s)
(For open procedure, see 50220-50240)

(For cryosurgical ablation, see 50250, 50593)

50543 partial nephrectomy
(For open procedure, use 50240)

50544 pyelopasty

50545 radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)
(For open procedure, use 50230)

50546 nephrectomy, including partial ureterectomy

50547 donor nephrectomy (including cold preservation), from living donor
(For open procedure, use 50320)

50548 nephrectomy with total ureterectomy
(For open procedure, see 50234, 50236)

50549 Unlisted lapaoscopy procedure, renal

(For laparoscopic drainage of lymphocele to peritoneal cavity, use 49323)

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

(When procedures 50570-50580 provide a significant identifiable service, they may be added to 50045 and 50120)

50570 Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;

(For nephrotomy, use 50045)
(For pyelotomy, use 50120)

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

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
(For imaging guidance and monitoring, see 76940, 77013, 77022)

50593 Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy **(Report required)**
(For imaging guidance and monitoring, see codes 76940, 77013, 77022)

URETER

INCISION

50600 Ureterotomy with exploration or drainage (separate procedure)

(For ureteral endoscopy performed in conjunction with this procedure, see 50970-50980)

50605 Ureterotomy for insertion of indwelling stent, all types
50610 Ureterolithotomy; upper one-third of ureter
50620 middle one-third of ureter
50630 lower one-third of ureter
(For laparoscopic approach, use 50945)

(For transvesical ureterolithotomy, use 51060)
(For cystotomy with stone basket extraction of ureteral calculus, use 51065)
(For endoscopic extraction or manipulation of ureteral calculus, see 50080, 50081, 50561, 50961, 50980, 52320-52330, 52352, 52353)

EXCISION

(For ureterocele, see 51535, 52300)

50650 Ureterectomy, with bladder cuff (separate procedure)
50660 Ureterectomy, total, ectopic ureter, combination abdominal, vaginal and/or perineal approach

INTRODUCTION

(For procedures 50684, 50690, radiological supervision and interpretation, use 74425)

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 stend via ileal conduit

(If imaging guidance is performed, use 75984)

50690 Injection procedure for visualization of ileal conduit and/or ureteropyelography, exclusive of radiologic service

REPAIR

(For bilateral procedure, for 50715, 50780, 50785, 50800, 50815, 50820, 50840, 50860, use modifier -50)

50700 Ureteroplasty, plastic operation on ureter (eg, stricture)
50715 Ureterolysis, with or without epositioning 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

(Codes 50780-50785 include minor procedures to prevent vesicoureteral reflux)

50780 Ureteroneocystostomy; anastomosis of single ureter to bladder

(When combined with cystourethroplasty or vesical neck revision, use 51820)

50782 anastomosis of duplicated ureter to bladder
50783 with extensive ureteral tailoring
50785 with vesico-psoas hitch or bladder flap

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)

(For combination of 50800-50820 with cystectomy, see 51580-51595)

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 uretero-ureterostomy 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

(For ureteroplasty, ureteroylysis, see 50700-50860)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy), (separate procedure), use 49320.

50945 Laparoscopy, surgical; ureterolithotomy
50947 ureteroneocystostomy with cystoscopy and ureteral stent placement
50948 ureteroneocystostomy without cystoscopy and ureteral stent placement

(For open ureteroneocystostomy, see 50780-50785)

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

(When procedures 50970-50980 provide a significant identifiable service, they may be added to 50600)

50970 Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;

(For ureterotomy, use 50600)

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

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

(For imaging guidance, see 76942, 77002, 77012)

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
(For transurethral resection, see 52234-52240, 52305)

51535 Cystotomy for excision, incision, or repair of ureterocele
(For bilateral procedure, use modifier -50)

(For transurethra excision, use 52300)

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

(For pelvic exenteration for gynecologic malignancy, use 58240)

INTRODUCTION

51600 Injection procedure for cystography or voiding urethrocystography
(For radiological supervision and interpretation, see 74430, 74455)

51605 Injection procedure and placement of chain for contrast and/or chain urethrocystography
(For radiological supervision and interpretation, use 74430)

51610 Injection procedure for retrograde urethrocystography
(For radiological supervision and interpretation, use 74450)

51700 Bladder irrigation, simple, lavage and/or instillation

51703 Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon) **(Report required)**
(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 **(Report required)**

(If imaging guidance is performed, use 75984)

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)

(For urethropexy (Pereyra type), use 57289)

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

(For vaginal approach, see 57320-57330)

51920 Closure of vesicouterine fistula;
51925 with hysterectomy **(See Rule 14)**

(For closure of vesicoenteric fistula, see 44660, 44661)
(For closure of rectovesical fistula, see 45800-45805)

51940 Closure, exstrophy of bladder
(See also 54390)

51960 Enterocystoplasty, including intestinal anastomosis
51980 Cutaneous vesicostomy

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

51990 Laparoscopy, surgical; urethral suspension for stress incontinence
51992 sling operation for stress incontinence (eg, fascia or synthetic)

(For open sling operation for stress incontinence, use 57288)
(For reversal or removal of sling operation for stress incontinence, use 57287)

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 (For radiological supervision and interpretation, see 74440)

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
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.

To report insertion of a self-retaining, indwelling stent performed during diagnostic or therapeutic cystourethroscopy with ureteroscopy and/or pyeloscopy report 52332, in addition to primary procedure(s) performed.

52332 is used to report a unilateral procedure unless otherwise specified. For bilateral insertion of self-retaining, indwelling ureteral stents, use code 52332, and modifier -50.

To report cystourethroscopic removal of a self-retaining, indwelling ureteral stent, see 52310, 52315.

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

(For cystourethroscopy, with ureteroscopy and/or pyeloscopy, see 52351-52355)
(For cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves or obstructive hypertrophic mucosal folds, use 52400)
(For percutaneous nephrostolithotomy, see 50080, 50081; for establishment of nephrostomy tract only, see 50395)

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)

(For transurethral resection or incision of ejaculatory ducts, use 52402)

52351 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic
(Do not report 52351 in conjunction with 52341-52346, 52352-52355)
(For radiological supervision and interpretation, use 74485)

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

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
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)

(For other approaches, see 55801-55845)

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

(For litholapaxy, use 52317, 52318)

URETHRA

(For endoscopy, see cystoscopy, urethroscopy, cystourethroscopy, 52000-52700)
(For injection procedure for urethrocystography, see 51600-51610)

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

(For subcutaneous abscess, see 10060, 10061)

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

(For endoscopic approach, see 52214, 52224)

53265 urethral caruncle

53270 Skene's glands
53275 urethral prolapse

REPAIR

(For hypospadias, see 54300-54352)

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) **(Report required)**
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 11040-11043 in addition to 53448)
53449 Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff **(Report required)**
53450 Urethromeatoplasty, with mucosal advancement

(For meatotomy, see 53020-53025)

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)

(For urethrolysis by retropubic approach, use 53899)

53502 Urethrorrhaphy, suture of urethral wound or injury; female **(Report required)**
53505 penile
53510 perineal
53515 prostatomembranous
53520 Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)

(For closure of urethrovaginal fistula, use 57310)
(For closure of urethrorectal fistula, see 45820, 45825)

MANIPULATION

(For radiological supervision and interpretation, use 74485)

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
(For insertion of permanent urethral stent, use 52282)

53899 Unlisted procedure, urinary system

MALE GENITAL SYSTEM

PENIS

INCISION

(For abdominal perineal gangrene debridement, see 11004-11006)

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

(For skin and subcutaneous abscess, see 10060-10160)

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) **(Report required)**

(For destruction or excision of other lesions, see **Integumentary System**)

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

(For lymphadenectomy (separate procedure), see 38760-38770)

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
(For radiological supervision and interpretation, use 74445)

54240 Penile plethysmography
54250 Nocturnal penile tumescence and/or rigidity test

REPAIR

(For other urethroplasties, see 53400-53430)
(For penile revascularization, see 37788)

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

(For urethroplasty and straightening of chordee, use 54308)

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 **(Report required)**
54390 with exstrophy of bladder
54400 Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401 inflatable (self contained)

(For removal or replacement of penile prosthesis, see 54415, 54416)

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 11040-11043 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 11040-11043 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
54440 Plastic operation of penis for injury

MANIPULATION

54450 Foreskin manipulation including lysis of preputial adhesions and stretching

TESTIS

EXCISION

(For abdominal perineal gangrene debridement, see 11004-11006)

54500 Biopsy of testis, needle (separate procedure)

(For fine needle aspiration, see 10021, 10022)

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

(For orchiectomy with repair of hernia, see 49505 or 49507 and 54520)
(For radical retroperitoneal lymphadenectomy, use 38780)

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 approach, with or without hernia repair
(For bilateral procedure, use modifier -50)

(For inguinal hernia repair performed in conjunction with inguinal orchiopexy, see 49495-49525)

54650 Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)
(For laparoscopic approach, use 54692)

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. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

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)

(For debridement of necrotizing soft tissue infection of external genitalia, see 11004-11006)

EXCISION

54800 Biopsy of epididymis, needle

(For fine needle aspiration, see 10021, 10022)

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

(With hernia repair, see 49495, 49501)

REPAIR

55060 Repair of tunica vaginalis hydrocele (Bottle type)

SCROTUM

INCISION

55100 Drainage of scrotal wall abscess
(See also 54700)

(For debridement of necrotizing soft tissue infection of external genitalia, see 11004-11006)

55110 Scrotal exploration
55120 Removal of foreign body in scrotum

EXCISION

(For excision, local lesion of scrotum skin, see **Integumentary System**)

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 bilatera (separate procedure), including postoperative semen examination(s) **(See Rule 13)**

REPAIR

55400 Vasovasostomy, vasovasorrhaphy
(For bilateral procedure, use modifier -50)

SUTURE

55450 Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure) **(See Rule 13)**

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. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

55550 Laparoscopy, surgical, with ligation of spermatic veins for vericocele
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

(For injection procedure, see 52010)

PROSTATE

INCISION

55700 Biopsy, prostate; needle or punch, single or multiple, any approach

(If imaging guidance is performed, use 76942)
(For fine needle aspiration, see 10021, 10022)

55705 incisional, any approach
55720 Prostatotomy, external drainage of prostatic abscess, any approach; simple
55725 complicated

(For transurethral drainage, use 52700)

EXCISION

(For transurethral removal of prostate, see 52601-52640)
(For transurethral destruction of prostate, see 53850-53852)
(For limited pelvic lymphadenectomy for staging (separate procedure), use 38562)
(For independent node dissection, see 38770-38780)

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)

(For laparoscopic retropubic radical prostatectomy, use 55866)

55860 Exposure of prostate, any approach, for insertion of radioactive substance;

(For application of interstitial radioelement, see 77776-77778)

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. To report a diagnostic laparoscopy (peritoreoscopy) (separate procedure), use 49320

55866 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing
(For open procedure, use 55840)

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

(For placement of needles or catheters into pelvic organs and/or genitalia [except prostate] for interstitial radioelement application, use 55920)
(For interstitial radioelement application, see 77776-77784)
(For ultrasonic guidance for interstitial radioelement application, see 76965)

55876 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, prostate, single or multiple

(For imaging guidance, see 76942, 77002, 77012, 77021)

55899 Unlisted procedure, male genital system

REPRODUCTIVE SYSTEM PROCEDURES

55920 Placement of needles or catheters into pelvic organs and/ or genitalia (except prostate) for subsequent interstitial radioelement application

(For placement of needles or catheters into prostate, use 55875)
(For insertion of heyman capsules for clinical brachytherapy, use 58346)
(For insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy, use 57155)

FEMALE GENITAL SYSTEM

(For pelvic laparotomy, use 49000)
(For paracentesis, see 49080, 49081)
(For secondary closure of abdominal wall evisceration or disruption, use 49900)
(For fulguration or excision of lesions, laparoscopic approach, use 58662)
(For chemotherapy, see 96405-96549)

(For excision or destruction of endometriomas, open method, see 49203-49205, 58957, 58958)

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

(For incision and drainage of sebaceous cyst, furuncle, or abscess, see 10040, 10060, 10061)

56405 Incision and drainage of vulva or perineal abscess
56420 Incision and drainage of Bartholin's gland abscess

(For incision and drainage of Skene's gland abscess or cyst, use 53060)

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)

(For destruction of Skene's gland cyst or abscess, use 53270)
(For cautery destruction of urethral caruncle, use 53265)

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)

(For excision of local lesion, see 11420-11426, 11620-11626)

56620 Vulvectomy simple; partial
56625 complete

(For skin graft, see 15002 et seq)

56630 Vulvectomy, radical, partial;

(For skin graft, if used, see 15004-15005, 15120, 15121, 15240, 15241)

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)

(For lymphadenectomy, see 38760-38780)

56700 Partial hymenectomy or revision of hymenal ring
56740 Excision of Bartholin's gland or cyst

(For excision of Skene's gland, use 53270)
(For excision of urethral caruncle, use 53265)
(For excision or fulguration of urethral carcinoma, use 53220)
(For excision or marsupialization of urethral diverticulum, see 53230-53240)

REPAIR

(For repair of urethra for mucosal prolapse, use 53275)

56800 Plastic repair of introitus
56805 Clitoroplasty for intersex state
56810 Perineoplasty, repair of perineum, non-obstetrical (separate procedure)
(See also 56800)

(For repair of wounds to genitalia, see 12001-12007, 12041-12047, 13131-13133)
(For anal sphincteroplasty, see 46750, 46751)
(For repair of recent injury of vagina and perineum, nonobstetrical, use 57210)
(For episiorrhaphy, episioperineorrhaphy for recent injury of vulva and/or perineum, nonobstetrical, use 57210)

ENDOSCOPY

56820 Colposcopy of the vulva;
56821 with biopsy(s)

(For colposcopic examinations/procedures involving the vagina, see 57420, 57421; cervix, see 57452-57461)

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)
57112 with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)
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 tandems and/or vaginal ovoids for clinical brachytherapy

(For placement of needles or catheters into pelvic organs and/or genitalia [except prostate] for interstitial radioelement application, use 55920)
(For insertion of radioelement sources or ribbons, see 77761-77763, 77781-77784)

57160 Fitting and insertion of pessary or other intravaginal support device
57180 Introduction of any hemostatic agent or pack for spontaneous or traumatic non-obstetrical hemorrhage (separate procedure)

REPAIR

(For urethral suspension, Marshall-Marchetti- Krantz type, abdominal approach, see 51840, 51841)
(For laparoscopic suspension, use 51990)

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
57250 Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy

(For repair of rectocele (separate procedure) without posterior colporrhapy, use 45560)

57260 Combined anteroposterior colporrhaphy;
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)
(Use 57267 in addition to 45560, 57240-57265)

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)
(For laparoscopic approach, use 51992)

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
(For laparoscopic approach, use 57426)

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 **(Report required)**
57320 Closure of vesicovaginal fistula; vaginal approach

(For concomitant cystostomy, see 51020-51040, 51101, 51102)

57330 transvesical and vaginal approach
(For abdominal approach, use 51900)

57335 Vaginoplasty for intersex state

MANIPULATION

57400 Dilation of vagina under anesthesia (other than local)
57410 Pelvic examination under anesthesia (other than local) **(Report required)**
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

(For colposcopic visualization of cervix and adjacent upper vagina; use 57452)
(For colposcopic examinations/procedures involving the vulva, see 56820, 56821; cervix, see 57452-57461)
(For endometrial sampling (biopsy) performed in conjunction with colposcopy, use 58110)

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

(For colposcopic examinations/procedures involving the vulva, see 56820, 56821, vagina, see 57420, 57421)

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)

(For endometrial sampling (biopsy) performed in conjunction with colposcopy, use 58110)

EXCISION

(For radical surgical procedures, see 58200-58240)

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)

(For radical abdominal hysterectomy, use 58210)

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

(For insertion of intrauterine device, use 58300)
(For insertion of any hemostatic agent or pack for control of spontaneous non-obstetrical hemorrhage, see 57180)

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)

(For endocervical currettage only, use 57505)
(For endometrial sampling (biopsy) performed in conjunction with colposcopy (57420, 57421, 57452-57461), use 58110)

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)

(For postpartum hemorrhage, use 59160)

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)

(For urethrocystopexy without hysterectomy, see 51840, 51841)

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)

(For radical hysterectomy with ovarian transposition, use also 58825)

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

(For pelvic ententeration for lower urinary tract or male genital malignancy, use 51597)

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

(For repair of enterocele with removal of tubes and/or ovaries, use 58263)

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

INTRODUCTION

(For insertion, removal and supply of implantable contraceptive capsules, see 11975, 11976, 11977)

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

(For radiological supervision and interpretation of saline infusion sonohysterography, use 76831)
(For radiological supervision and interpretation of hysterosalpingography, use 74740)

58346 Insertion of Heyman capsules for clinical brachytherapy

(For placement of needles or catheters into pelvic organs and/or genitalia [except prostate] for interstitial radioelement application, use 55920)
(For insertion of radioelement sources or ribbons, see 77761-77763, 77781-77784)

58353 Endometrial ablation, thermal, without hysteroscopic guidance

(For hysteroscopic procedure, use 58563)

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) **(Report required)**

(For closure of vesicouterine fistula, use 51920)

LAPAROSCOPY / HYSTEROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320. To report a diagnostic hysteroscopy (separate procedure), use 58555.

(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)

(Do not report 58541-58544, 58550-58552, 58553-58554, 58570-58575 in conjunction with 49320, 57000, 57180, 57410, 58140-58146, 58150, 58545, 58546, 58561, 58661, 58670, 58671)

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)

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)
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)

(For laparoscopic procedures, use 58670, 58671)

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
(For laparoscopic approach, use 58671)

(For lysis of adnexal adhesions, use 58740)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

(**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

(For laparoscopic aspiration of ovarian cyst, use 49322)
(For laparoscopic biopsy of the ovary or fallopian tube, use 49321)

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)
(For laparascopic approach, use 58660)

(For fulguration or excision of lesions, laparascopic approach, use 58662)
(For excision/destruction of endometriomas, open method, see 49203-49205, 58957, 58958)

58770 Salpingostomy (salpingoneostomy)
(For laparoscopic approach, use 58673)

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
58823 Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)
(For radiological supervision and interpretation, use 75989)

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)

(For laparoscopic biopsy of the ovary or fallopian tube, use 49321)

58920 Wedge resection or bisection of ovary, unilateral or bilateral
58925 Ovarian cystectomy, unilateral or bilateral
58940 Oophorectomy, partial or total, unilateral or bilateral;

(For oophorectomy with concomitant debulking for ovarian malignancy, use 58952)

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)

(For resection of recurrent ovarian, tubal, primary peritoneal, or uterine malignancy, see 58957, 58958)

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.

Epidurals are to be billed using the delivery code with the -AA modifier. The number of units should indicate the actual face to face time spent with the patient.

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.

(For circumcision of newborn, see 54150, 54160)

Reimbursement amounts for the Medicaid Obstetrical and Maternal Services Program (MOMS), are noted in the Surgery excel Fee Schedule. For information on the MOMS Program, see Policy Section.

FETAL INVASIVE SERVICES

59000 Amniocentesis; diagnostic
(For radiological supervision and interpretation, use 76946)

59001 therapeutic amniotic fluid reduction (includes ultrasound guidance)

59012 Cordocentesis (intrauterine), any method
(For radiological supervision and interpretation, use 76941)

59015 Chorionic villus sampling, any method
(For radiological supervision and interpretation, use 76945)

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

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 **(Report required)**
59150 Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy
59151 with salpingectomy and/or oophorectomy
59160 Curettage, postpartum

INTRODUCTION

(For intrauterine fetal transfusion, use 36460)
(For introduction of hypertonic solution and/or prostaglandins to initiate labor, see 59850-59857)

59200 Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)

REPAIR

(For trancheloplasty, use 57700)

59300 Episiotomy or vaginal repair, by other than attending physician
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
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

(For low cervical or classical cesarean section, see 59510, 59515, 59525)

59510 Routine obstetric care including antepartum care, cesarean delivery, and **(inpatient and outpatient)** postpartum care (total, all-inclusive, "global" care)

59514 Caesarean 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)

(For extraperitoneal cesarean section, or cesarean section with subtotal or total hysterectomy, see 59510, 59515, 59525)

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/Mcode(s) for postpartum care visits)

59622 including **(inpatient and outpatient)** postpartum care

ABORTION

(For surgical treatment of spontaneous abortion, use 59812)
(For medical treatment of spontaneous complete abortion, any trimester, use E&M codes 99201-99233)
(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)

(For insertion of cervical dilator, use 59200)

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)
59898 Unlisted laparoscopy procedure, maternity care and delivery
59899 Unlisted procedure, maternity care and delivery

ENDOCRINE SYSTEM

(For pituitary and pineal surgery, see Nervous System)

THYROID GLAND

INCISION

60000 Incision and drainage of thyroglossal duct cyst, infected

EXCISION

60100 Biopsy thyroid, percutaneous core needle
(If image guidance is performed, see 76942, 77002, 77012, 77021)
(For fine needle aspiration, use 10021, 10022)
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

(For thyroidectomy, subtotal or partial, use 60271)

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

(For thyroid ultrasonography, see 76536)

REMOVAL

60300 Aspiration and/or injection, thyroid cyst

(For fine needle aspiration, see 10021, 10022)
(If imaging guidance is performed, see 76942, 77012)

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)

(For excision of remote or disseminated pheochromocytoma, see 49203-49205)

60600 Excision of carotid body tumor; without excision of carotid artery
60605 with excision of carotid artery

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

60650 Laparoscopy, surgical; with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal
60659 Unlisted laparoscopiy procedure, endocrine system

OTHER PROCEDURES

60699 Unlisted procedure, endocrine system

NERVOUS SYSTEM

SKULL, MENINGES, AND BRAIN

(For injection procedure for cerebral angiography, see 36100-36218)
(For injection procedure for ventriculography, see 61026, 61120)
(For injection procedure for pneumoencephalography, use 61055)

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 (Cl-C2) puncture; without injection (separate procedure)
61055 with injection of medicament or other substance for diagnosis or treatment (Cl-C2)
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

(For refilling and maintenance of an implantable infusion pump for spinal or brain drug therapy, use 95990)

(For chemotherapy, use 96450)

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)

(For subtemporal decompression, use 61340)

61330 Decompression of orbit only, transcranial approach
(For bilateral procedure, use modifier -50)

61332 Exploration of orbit (transcranial approach); with biopsy
61333 with removal of lesion
61334 with removal of foreign body
61340 Subtemporal cranial decompression (pseudotumor cerebri, slit ventrical syndrome)
(For bilateral procedure, use modifier -50)

(For decompressive craniotomy or craniectomy for intracranial hypertension, without hematoma evacuation, see 61322, 61323)

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

(For orbital decompression by lateral wall approach, kroenlein type, use 67445)

61440 Craniotomy for section of tentorium cerebelli (separate procedure)
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
61470 for medullary tractotomy
61480 for mesencephalic tractotomy or pedunculotomy
61490 Craniotomy for lobotomy, including cingulotomy
(For bilateral procedure, use modifier -50)

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

(For excision of pituitary tumor or craniopharyngioma, see 61545, 61546, 61548)

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 ribons, 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

(For stereotactic implantation of electrodes, see 61760)
(For craniotomy for excision of intracranial arteriovenous malformation, see 61680-61692)

61533 Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring

(For continuous EEG monitoring, see 95950-95954)

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
61542 for total hemispherectomy
61543 for partial or subtotal (functional) hemispherectomy
61544 for excision or coagulation of choroid plexus
61545 for excision of craniopharyngioma

(For craniotomy for selective amygdalohippocampectomy, use 61566)
(For craniotomy for multiple subpial transections during surgery, use 61567)

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

(For cranial reconstruction for orbital hypertelorism, see 21260-21263)
(For reconstruction, see 21172-21180)

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)

(For reconstruction, see 21172-21180)

61563 Excision, intra- and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); without optic nerve decompression **(Report required)**
61564 with optic nerve decompression

(For reconstruction, see 21181-21183)

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

(For sequestrectomy for osteomyelitis, use 61501)

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)

(For arthrodesis, use 22548)

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.

For primary closure, see the appropriate codes, ie, 15732, 15756-15758.

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

(Codes 61609-61612 are reported in addition to code(s) for primary procedure(s) 61605-61608). Report only one transection or ligation of cartoid artery code per operative session)

61609 Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to primary procedure)

61610 with repair by anastomosis or graft (List separately in addition to primary procedure)

61611 Transection or ligation, carotid artery in petrous canal; without repair (List separately in addition to primary procedure)

61612 with repair by anastomosis or graft (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 CI-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

(If selective catheterization and angiography of arteries other than artery to be occluded is performed, use appropriate catheterization and radiologic supervision and interpretation codes)
(If complete diagnostic angiography of the artery to be occluded is performed immediately prior to temporary occlusion, use appropriate radiologic supervision and interpretation codes only)

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)
(For radiological supervision and interpretation, use 75894)
(See also 37204)

61626 non-central nervous system, head or neck (extracranial, brachiocephalic branch)
(For radiological supervision and interpretation, use 75894)
(See also 37204)

61630 Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous **(Report required)**

61635 Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed **(Report required)**

(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 **(Report required)**

61641 each additional vessel in same vascular family **(Report required)**
(List separately in addition to primary procedure)

61642 each additional vessel in different vascular family **(Report required)**
(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)

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; cartoid circulation
61698 veretrobasilar 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 occulsion, 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)

(For cervical approach for direct ligation of carotid artery, see 37600-37606)

61705 Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery
61708 by intracranial electrothrombosis

(For ligation or gradual occlusion of internal/common carotid artery, see 37605, 37606)

61710 by intra-arterial embolization, injection procedure, or balloon catheter
61711 Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical) arteries

(For carotid or vertebral thromboendarterectomy, use 35301)

STEREOTAXIS

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

(For radiological supervision and interpretation of computerized tomography, see 70450, 70460, or 70470 as appropriate)
(For radiological supervision and interpretation of magnetic resonance imaging, see 70551, 70552, or 70553 as appropriate)

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

61790 Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); gasserian ganglion

61791 trigeminal medullary tract **(Report required)**

STEREOTACTIC RADIOSURGERY (CRANIAL)

61795 Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal
(List separately in addition to primary procedure)

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)

61870 Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical
61875 subcortical
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

(For open placement of cranial nerve (eg, vagal, trigeminal, neurostimulator electrode(s), use 64573)
(For percutaneous placement of cranial nerve (eg, vagal, trigeminal) neurostimulator electrode(s), use 64553)
(For revision or removal of cranial nerve (eg, vagal, trigeminal) neurostimulator electrode(s), use 64585)

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

(For repair of spinal dural/CSF leak, see 63707 or 63709)

62115 Reduction of craniomegalic skull (eg, treated hydrocephalus); not requiring bone grafts or cranioplasty
62116 with simple 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
62163 with retrieval of foreign body
62164 with excision of brain tumor, including placement of external ventricular catheter for drainage
62165 with excision of pituitary tumor, transnasal or transphenoidal 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

(For intracranial neuroendoscopic procedures, see 62161-62165)

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

(For percutaneous irrigation or aspiration of shunt reservoir, use 61070)
(For reprogramming of programmable CSF shunt, use 62252)

SPINE AND SPINAL CORD

(For application of caliper or tongs, use 20660)
(For treatment of fracture or dislocation of spine, see 22305-22327)

INJECTION, DRAINAGE OR ASPIRATION

Injection of contrast during fluoroscopic guidance and localization is an inclusive component of codes 62263-62264, 62270-62273, 62280-62282, 62310-62319. 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.

For radiologic supervision and interpretation of epidurography, use 72275. Code 72275 is only to be used when a epidurogram is performed, images documented, and a formal radiologic report is issued.

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.

(For daily hospital management of continuous epidural or subarachnoid drug administration performed in conjunction with codes 62318-62319, see E/M services.)

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 10022, 20225, 62287, 62290, 62291)
(For imaging, see 77003, 77012)

62268 Percutaneous aspiration, spinal cord cyst or syrinx
(For radiological supervision and interpretation, see 76942, 77002, 77012)

62269 Biopsy of spinal cord, percutaneous needle
(For radiological supervision and interpretation, see 76942, 77002, 77012)

(For fine needle aspiration, see 10021, 10022)

62270 Spinal puncture, lumbar, diagnostic

62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)

62273 Injection, epidural, of blood or clot patch

(For injection of diagnostic or therapeutic substance(s), see 62310, 62311, 62318, 62319)

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, spinal (other than C1-C2 and posterior fossa)

(For injection procedure at C1-C2, use 61055)
(For radiological supervision and interpretation, see Radiology)

62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous discectomy, percutaneous laser diskectomy)

(For fluoroscopic guidance, use 77002)
(For injection of non-neurolytic diagnostic or therapeutic substance(s), see 62310, 62311)

62290 Injection procedure for diskography, each level; lumbar
62291 cervical or thoracic
(For radiological supervision and interpretation, see 72285, 72295)

62292 Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar
62294 Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal
62310 Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steriod, other solution), epidural or subarachnoid; cervical or thoracic
62311 lumbar, sacral (caudal)
62318 Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) including anesthetic, antispasmodic, opioid, steriod, other solution) epidural or subarachnoid; cervical or thoracic
62319 lumbar, sacral (caudal)

(For transforaminal epidural injection, see 64479-64484)

CATHETER IMPLANTATION

(For percutaneous placement of intrathecal or epidural catheter, see codes 62270-62273, 62280-62284, 62310-62319)

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

(For refilling and maintenance of an implantable reservoir or infusion pump, for spinal or brain drug therapy, use 95990, 95991)

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 non-programmable 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
62368 with reprogramming

(For refilling and maintenance of an implantable infusion pump for spinal or brain drug therapy not involving reprogramming, use 95990, 95991)

POSTERIOR EXTRADURAL LAMINOTOMY OR LAMINECTOMY FOR EXPLORATION/ DECOMPRESSION OF NEURAL ELEMENTS OR EXCISION OF HERNIATED INTERVERTEBRAL DISKS

(When 63001-63048 are followed by arthrodesis, see 22590-22614)

63001 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (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 diskectomy, (eg. spinal stenosis), more than 2 vertebral segments; cervical
63016 thoracic
63017 lumbar

(For codes 63020 – 63044, for bilateral procedures, use modifier -50)

63020 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; including open and endoscopically-assisted approaches; 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, re-exploration, 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)

(For excision of thoracic intraspinal lesions by laminectomy, see 63266, 63271, 63276, 63281 and 63286)

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 Diskectomy, 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)

(For transoral approach, see 61575-61576)

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 diskectomy above and/or below vertebral segment)

(If followed by arthrodesis, see 22548-22812)

(For reconstruction of spine, use appropriate vertebral corpectomy codes 63081-63091, bone graft codes 20930-20938, arthrodesis codes 22548-22812, and spinal instrumentation codes 22840-22855)

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 plueral space
63180 Laminectomy and section of dentate ligaments, with or without dural graft, cervical; one or two segments
63182 more than two segments
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)

(For resection of sternocleidomastoid muscle, use 21720)

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 **(Report required)**
63199 thoracic **(Report required)**
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

(For drainage of intramedullary cyst/syrinx, use 63172, 63173)

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.

(For arthrodesis, see 22548-22632)
(For reconstruction of spine, see 20930-20938)

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) **(Report required)**
63610 Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery **(Report required)**
63615 Stereotactic biopsy, aspiration, or excision of lesion spinal cord **(Report required)**

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 neuro-stimulator 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

(For electronic analysis of implanted neurostimulator pulse generator system, see 95970-95975)

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

(For laminectomy and section of dentate ligaments, with or without dural graft, cervical, see 63180-63182)

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

(For insertion of subarachnoid catheter with reservoir and/or pump for intermittent or continuous infusion of drug including laminectomy, see 62351 and 62360, 62361 or 62362)

(For insertion or replacement of subarachnoid or epidural catheter, with reservoir and/or pump for drug infusion without laminectomy, see 62350 and 62360, 62361 or 62362)

EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM

(For intracranial surgery on cranial nerves, see 61450, 61460, 61790)

INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC 0R THERAPEUTIC:

SOMATIC NERVES

64400 Injection, anesthetic agent; trigeminal nerve, any division or branch
64402 facial nerve
64405 greater occipital nerve
64408 vagus nerve
64410 phrenic nerve
64412 spinal accessory nerve
64413 cervical plexus
64415 brachial plexus, single
64416 brachial plexus, continuous infusion by catheter (including catheter placement)
64417 axillary nerve
64418 suprascapular nerve
64420 intercostal nerve, single
64421 intercostal nerves, multiple, regional block
64425 ilioinguinal, iliohypogastric nerves
64430 pudendal nerve
64435 paracervical (uterine) nerve
64445 sciatic nerve, single
64446 sciatic nerve, continuous infusion by catheter, (including catheter placement)
64447 femoral nerve, single
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
64455 Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)
(Do not report 64455 in conjunction with 64632)

64479 Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level
64480 cervical or thoracic, each additional level
(List separately in addition to primary procedure)
(Use 64480 in conjunction with 64479)
64483 lumbar or sacral, single level
64484 lumbar or sacral, each additional level
(List separately in addition to primary procedure)
(Use 64484 in conjunction with 64483)
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)
(Use 64494, 64495 in conjunction with 64493)

SYMPATHETIC NERVES

64505 Injection, anesthetic agent; sphenopalatine ganglion
64508 carotid sinus (separate procedure)
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.

(For codes 64553, 64573 for open placement of cranial nerve (eg, vagal, trigeminal) neurostimulator pulse generator or receiver, see 61885, 61886, as appropriate)

64553 Percutaneous implantation of neurostimulator electrodes; cranial nerve
64555 peripheral nerve (excludes sacral nerve)
64560 autonomic nerve
64561 sacral nerve (transforaminal placement)
64565 neuromuscular **(Report required)**

64573 Incision for implantation of neurostimulator electrodes; cranial nerve

(For revision or removal of cranial nerve (eg, vagal, trigeminal) neurostimulator pulse generator or receiver, use 61888)

64575 peripheral nerve (excludes sacral nerve)
64577 autonomic nerve
64580 neuromuscular
64581 sacral nerve (transforaminal placement) **(Report required)**
64585 Revision or removal of peripheral neurostimulator electrodes
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, RADIOFREQUENCY)

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
64612 Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)
64613 neck muscle(s) (eg, for spasmodic torticollis, spasmotic dysphonia)
64614 extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)

(For chemodenervation of internal anal sphincter, use 46505)
(For chemodenervation for strabismus involving the extraocular muscles, use 67345)

64620 Destruction by neurolytic agent; intercostal nerve

(Codes 64622-64627 are unilateral procedures, for bilateral procedures use modifier -50)
(For fluoroscopic guidance and localization for needle placement and neurolysis in conjunction with 64622-64627, use 77003)

64622 Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level
64623 lumbar or sacral, each additional level
(List separately in addition to primary procedure)
(Use 64623 in conjunction with 64622)

64626 cervical or thoracic, single level
64627 cervical or thoracic, each additional level
(List separately in addition to primary procedure)
(Use 64627 in conjunction with 64626)

64630 Destruction by neurolytic agent; pudendal nerve
64632 plantar common digital nerve
(Do not report 64632 in conjunction with 64455)

64640 other peripheral nerve or branch

SYMPATHETIC NERVES

64650 Chemodenervation of eccrine glands; both axillae
64653 other area(s) (eg, scalp, face, neck), per day

(Report the specific service in conjunction with code(s) for the specific substance(s) or drug(s) provided)
(For chemodenervation of extremities (eg, hands or feet), use 64999)

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.

(For facial nerve decompression, use 69720)
(For neuroplasty with nerve wrapping, see 64702-64726, 64999)

64702 Neuroplasty; digital, one or both, same digit
64704 nerve of hand or foot
64708 Neuroplasty, major peripheral nerve, arm or leg; 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

(For arthroscopic procedure, use 29848)

64722 Decompression; unspecified nerve(s) (specify)
64726 plantar digital nerve
64727 Internal neurolysis, requiring use of operating microscope **(Report required)**
(List separately in addition to code for neuroplasty)
(Neuroplasty includes external neurolysis)

TRANSECTION OR AVULSION

(For stereotactic lesion of gasserian ganglion, use 61790)

64732 Transection or avulsion of; supraorbital nerve
64734 infraorbital nerve
64736 mental nerve
64738 inferior alveolar nerve by osteotomy
64740 lingual nerve **(Report required)**
64742 facial nerve, differential or complete **(Report required)**
64744 greater occipital nerve
64746 phrenic nerve

(For section of recurrent laryngeal nerve, use 31595)

64752 vagus nerve (vagotomy), transthoracic
64755 vagus nerve limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy)
(For laparoscopic approach, use 43652)

64760 vagus nerve (vagotomy), abdominal **(Report required)**
(For laparoscopic approach, use 43651)

(For procedures 64761, 64763, 64766, for bilateral procedure, use modifier -50)

64761 pudendal nerve **(Report required)**
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
64772 Transection or avulsion of other spinal nerve, extradural

(For excision of tender scar, skin and subcutaneous tissue, with or without tiny neuroma, see 11400-11446, 13100-13153)

EXCISION

SOMATIC NERVES

(For Morton neurectomy, use 28080)

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
64870 facial-phrenic
(Use 64872, 64874, 64876 in conjunction with 64831-64865)

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 **(Report required)**
(List separately in addition to code for nerve suture)

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

(For conjunctivoplasty after enucleation, see 68320 et seq)

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

(For skin graft to orbit (split skin), see 15120, 15121; free, full thickness, see 15260, 15261)
(For eyelid repair involving more than skin, see 67930 et seq)

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) **(Report required)**
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

(For orbital implant (implant outside muscle cone) insertion, use 67550; removal, use 67560)

REMOVAL OF FOREIGN BODY

(For removal of implanted material: ocular implant, use 65175; anterior segment implant, use 65920; posterior segment implant, use 67120; orbital implant, use 67560)
(For diagnostic X-ray for foreign body, use 70030)
(For diagnostic echography for foreign body, use 76529)
(For removal of foreign body from orbit: frontal approach, use 67413; lateral approach, use 67430; transcranial approach, use 61334)
(For removal of foreign body from eyelid, embedded, use 67938)
(For removal of foreign body from lacrimal system, use 68530)

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

(For repair of corneal laceration with foreign body, use 65275)

65235 Removal of foreign body, intraocular; from anterior chamber of eye or lens

(For removal of implanted material from anterior segment, use 65920)

65260 from posterior segment, magnetic extraction, anterior or posterior route
65265 from posterior segment, nonmagnetic extraction

(For removal of implanted material from posterior segment, use 67120)

REPAIR OF LACERATION

(For fracture of orbit, see 21385 et seq)
(For repair of wound of eyelid, skin, linear, simple, see 12011-12018; intermediate, layered closure, see 12051-12057; linear, complex, see 13150-13160; other, see 67930, 67935)
(For repair of wound of lacrimal system, use 68700)
(For repair of operative wound, use 66250)

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

(Repair of laceration includes use of conjunctival flap and restoration of anterior chamber, by air or saline injection when indicated)
(For repair of iris or ciliary body, use 66680)

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

65760 Keratomileusis
65765 Keratophakia
65767 Epikeratoplasty **(Report required)**
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 **(Report required)**

(For unlisted procedures on cornea, use 66999)

ANTERIOR CHAMBER

INCISION

65800 Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous
65805 with therapeutic release 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

(For injection, see 66020-66030)
(For removal of blood clot, use 65930)

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)

(For trabeculectomy, use 66170)

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

(For trabeculoplasty by laser surgery, use 65855)

65870 anterior synechiae, except goniosynechiae
65875 posterior synechiae
(For use of ophthalmic endoscope with 65875, use 66990)

65880 corneovitreal adhesions

(For laser surgery, use 66821)

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

(For unlisted procedures on anterior segment, use 66999)

ANTERIOR SCLERA

EXCISION

(For removal of intraocular foreign body, use 65235)
(For operations on posterior sclera, use 67250-67255)

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
66165 iridencleisis or iridotasis
66170 trabeculectomy ab externo in absence of previous surgery

(For trabeculotomy ab externo, use 65850)
(For repair of operative wound, use 66250)

66172 trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)

AQUEOUS SHUNT

66180 Aqueous shunt to extraocular reservoir, (eg, Molteno, Schocket, Denver-Krupin)
66185 Revision of aqueous shunt to extraocular reservoir

(For removal of implanted shunt, use 67120)

REPAIR OR REVISION

(For scleral procedures in retinal surgery, see 67101 et seq)

66220 Repair of scleral staphyloma; without graft **(Report required)**
66225 with graft **(Report required)**

(For scleral reinforcement, see 67250, 67255)

66250 Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure

(For unlisted procedure on anterior sclera, use 66999)

IRIS, CILIARY BODY

INCISION

66500 Iridotomy by stab incision (separate procedure); except transfixion
66505 with transfixion as for iris bombe

(For iridotomy by photocoagulation, use 66761)

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)

(For coreoplasty by photocoagulation, use 66762)

REPAIR

66680 Repair of iris, ciliary body (as for iridodialysis)

(For reposition or resection or uveal tissue with perforating wound of cornea or sclera, use 65285)

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
(Do not report 66711 in conjunction with 66990)
66720 cryotherapy
66740 cyclodialysis
66761 Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (one or more sessions)
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) **(Report required)**

(For excision lesion iris, ciliary body, see 66600, 66605)
(For removal epithelial downgrowth, use 65900)
(For unlisted procedures on iris, ciliary body, use 66999)

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)

(For removal of intralenticular foreign body without lens extraction, use 65235)
(For repair of operative wound, use 66250)

INTRAOCULAR LENS PROCEDURES

66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one 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

66983 Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)

66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)

(For complex extracapsular cataract removal, use 66982)

66985 Insertion of intraocular lens prosthesis (secondary implant)not associated with concurrent cataract removal
(For use of ophthalmic endoscope with 66985, use 66990)

(To code implant at time of concurrent cataract surgery, see 66982, 66983 or 66984)
(For ultrasonic determination of intraocular lens power, use 76519)
(For removal of implanted material from anterior segment, use 65920)
(For secondary fixation (separate procedure) use 66682)

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, 67112)

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

(For removal of vitreous by paracentesis of anterior chamber, use 65810)
(For removal of corneovitreal adhesions, see 65880)

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

(For removal, use 67121)

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

(For use of ophthalmic endoscope with 67036, 67039, 67040-67043, use 66990)
(For associated lensectomy, use 66850)
(For use of vitrectomy in retinal detachment surgery, see 67108, 67113)
(For associated removal of foreign body, see 65260, 65265)
(For unlisted procedures on vitreous, use 67299)

RETINA OR CHOROID

REPAIR

(If diathermy, cryotherapy and/or photocoagulation are combined, report under principal modality used)

67101 Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid
67105 photocoagulation with or without drainage of subretinal fluid
67107 Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photo-coagulation 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)
67112 by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques
(For use of ophthalmic endoscope with 67112, use 66990)

(For aspiration or drainage of subretinal or subchoroidal fluid, use 67015)

67113 Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy ofprematurity, 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

(To report vitrectomy, pars plana approach, other than in retinal detachment surgery, see 67036-67043)

67115 Release of encircling material (posterior segment)
67120 Removal of implanted material, posterior segment; extraocular
67121 intraocular

(For removal from anterior segment, use 65920)
(For removal of foreign body, see 65260, 65265)

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)

(For unlisted procedures on retina, use 67299)

POSTERIOR SCLERAL

REPAIR

(For excision lesion sclera, use 66130)

67250 Scleral reinforcement (separate procedure); without graft
67255 with graft

(For repair scleral staphyloma, see 66220, 66225)

OTHER PROCEDURES

67299 Unlisted procedure, posterior segment

OCULAR ADNEXA

EXTRAOCULAR MUSCLES

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)

(For adjustable sutures, use 67335 in addition to codes 67311-67334 for primary procedure reflecting number of muscles operated on)

67318 Strabismus surgery, any procedure superior oblique muscle

(Use 67320, 67331, 67332, 67334 in conjunction with 67311-67318)

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)

(Use 67335, 67340, in conjunction with 67311-67334)

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)
(Use 67343 in conjunction with 67311-67340, when such procedures are performed other than on the affected muscle)

67345 Chemodenervation of extraocular muscle

(For chemodenervation for blepharospasm and other neurological disorders, see 64612 and 64613)

67346 Biopsy of extraocular muscle

(For repair of wound, extraocular muscle, tendon or Tenon's capsule, use 65290)

OTHER PROCEDURES

67399 Unlisted procedure, ocular 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

(For exenteration, enucleation, and repair, see 65101 et seq)
(For optic nerve decompression use 67570)

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

(For optic nerve sheath decompression, use 67570)

67450 for exploration, with or without biopsy

(For orbitotomy, transcranial approach, see 61330-61334)
(For orbital implant, see 67550, 67560)
(For removal of eyeball or for repair after removal, see 65091-65175)

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

(For subconjunctival injection, use 68200)

67550 Orbital implant (implant outside muscle cone); insertion
67560 removal or revision

(For ocular implant (implant inside muscle cone), see 65093-65105, 65130-65175)
(For treatment of fractures of malar area, orbit, see 21355 et seq)

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)

(For canthoplasty, use 67950)
(For division of symblepharon, use 68340)

EXCISION, DESTRUCTION

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

(For removal of lesion, involving mainly skin of eyelid, see 11310-11313; 11440-11446; 11640-11646; 17000-17004)
(For repair of wounds, blepharoplasty, grafts, reconstructive surgery, see 67930-67975)

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 Biopsy of eyelid
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

(For excision and repair of eyelid by reconstructive surgery, see 67961-67966)

67850 Destruction of lesion of lid margin (up to 1 cm) **(Report required)**

(For Mohs' micrographic surgery, see 17311-17315)
(For initiation or follow-up care of topical chemotherapy, eg, 5-FU or similar agents, see appropriate office Evaluation and Management service)

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

(For severing of tarsorrhaphy, Use 67710)
(For canthoplasty, reconstruction canthus, Use 67950)
(For canthotomy, Use 67715)

REPAIR (BROW PTOSIS, BLEPHAROPTOSIS, LID RETRACTION, ECTROPION, ENTROPION)

67900 Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

(For forehead rhytidectomy, use 15824)

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

(For obtaining autogenous graft material, see 20920, 20922 or 20926)
(For correction trichiasis by mucous membrane graft, use 67835)

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)

(For correction everted punctum, use 68705)

67921 Repair of entropion; suture
67922 thermocauterization
67923 excision tarsal wedge
67924 extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)

(For repair cicatricial ectropion or entropion requiring scar excision or skin graft, see also 67961 et seq)

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

(For repair of skin of eyelid, see 12011-12018; 12051-12057; 13150-13153)
(For tarsorrhaphy, canthorrhaphy, see 67880-67882)
(For repair of blepharoptosis and lid retraction, see 67901-67911)
(For blepharoplasty for entropion, ectropion, see 67916, 67917, 67923, 67924)
(For correction of blepharochalsis (blepharorhytidectomy), see 15820-15823)
(For repair of skin of eyelid, adjacent tissue transfer, see 14060, 14061; preparation for graft, use 15004; free graft, see 15120, 15121, 15260, 15261)
(For excision of lesion of eyelid, use 67800 et seq)
(For repair of lacrimal canaliculi, use 68700)

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

(For canthoplasty, use 67950)
(For free skin grafts, see 15120, 15121, 15260, 15261)
(For tubed pedicle flap preparation, use 15576; for delay, use 15630; for attachment, use 15650)

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

(For removal of foreign body, see 65205 et seq)

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 **(Report required)**
68135 Destruction of lesion, conjunctiva

INJECTION

(For injection into Tenon's capsule or retrobulbar injection, see 67500-67515)

68200 Subconjunctival injection

CONJUNCTIVOPLASTY

(For wound repair, see 65270-65273)

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)

(For conjunctival flap for perforating injury, see 65280, 65285)
(For repair of operative wound, use 66250)
(For removal of conjunctival foreign body, see 65205, 65210)

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
(For radiological supervision and interpretation, see 70170, 78660)

OTHER PROCEDURES

68899 Unlisted procedure, lacrimal system

AUDITORY SYSTEM

(For diagnostic services, eg, audiometry, vestibular tests, see 92502 et seq)

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

(For reconstruction of ear, see 15120 et seq)

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

(For resection of temporal bone, use 69535)
(For skin grafting, see 15004-15261)

REMOVAL

(For codes 69220, 69222, for bilateral procedures use modifier -50)

69200 Removal foreign body from external auditory canal; without general anesthesia **(Report required)**
69205 with general anesthesia
69220 Debridement, mastoidectomy cavity, simple (eg, routine cleaning)
69222 Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)

REPAIR

(For suture of wound or injury of external ear, see 12011-14302)

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

(For combination with middle ear reconstruction, see 69631, 69641)
(For other reconstructive procedures with grafts (eg, skin, cartilage, bone), see 13150-15760, 21230-21235)

OTHER PROCEDURES

(For otoscopy under general anesthesia, see 92502)

69399 Unlisted procedure, external ear

MIDDLE EAR

INTRODUCTION

69400 Eustachian tube inflation, transnasal; with catheterization
69401 without catheterization
69405 Eustachian tube catheterization, transtympanic

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
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

(For atticotomy, see 69601 et seq)

69450 Tympanolysis, transcanal

EXCISION

69501 Transmastoid antrotomy (simple mastoidectomy)
69502 Mastoidectomy; complete
69505 modified radical
69511 radical

(For skin graft, see 15004 et seq)
(For mastoidectomy cavity debridement, see 69220-69222)

69530 Petrous apicectomy including radical mastoidectomy
69535 Resection temporal bone, external approach **(Report required)**

(For middle fossa approach, see 69950-69970)

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

(For planned secondary tympanoplasty after mastoidectomy, see 69631, 69632)

69605 with apicectomy

(For skin graft, see 15120, 15121, 15260, 15261)

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)

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 **(Report required)**

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

(For extracranial suture of facial nerve, use 64864)

69799 Unlisted procedure, middle ear

INNER EAR

INCISION AND/OR DESTRUCTION

69801 Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); transcanal (69801 includes all required infusions performed on initial and subsequent days of treatment)
(69801 includes all required infusions performed on initial and subsequent days of treatment)

69802 with mastoidectomy

69805 Endolymphatic sac operation; without shunt

69806 with shunt

69820 Fenestration semicircular canal

69840 Revision fenestration operation

EXCISION

69905 Labyrinthectomy; transcanal

69910 with mastoidectomy

69915 Vestibular nerve section, translabyrinthine approach **(Report required)**

(For transcranial approach, use 69950)

INTRODUCTION

69930 Cochlear device implantation, with or without mastoidectomy

OTHER PROCEDURES

69949 Unlisted procedure, inner ear

TEMPORAL BONE, MIDDLE FOSSA APPROACH

(For external approach, use 69535)

69950 Vestibular nerve section, transcranial approach **(Report required)**
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