NEW YORK STATE

MEDICAID PROGRAM

PHYSICIAN – PROCEDURE CODES

SECTION 5 - SURGERY
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GENERAL INFORMATION AND RULES

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

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

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

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

5. **SEPARATE PROCEDURE:**
   Certain of the listed procedures are commonly carried out as an integral part of a total service and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "Separate Procedure" is applicable.

6. **MULTIPLE SURGICAL PROCEDURES:**
   a. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total dollar value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s) unless otherwise specified. (For reporting bilateral surgical procedures, see modifier -50).
b. When an incidental procedure (eg, incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the fee will be that of the major procedure only.

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

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

9. SKILLS OF TWO SURGEONS
a. When the skills of two surgeons are required in the management of a specific surgical procedure, by prior agreement, the total dollar value may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. The value may be increased by 25 percent under these circumstances. See MMIS modifier -62.

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

10. MATERIALS SUPPLIED BY A PHYSICIAN:
Supplies and materials provided by the physician, eg, sterile trays/drugs, over and above those usually included with the office visit or other services rendered may be listed separately. List drugs, trays, supplies and materials provided. Identify as 99070. Reimbursement for drugs (including vaccines and immunoglobulin) furnished by practitioners to their patients is based on the acquisition cost to the practitioner of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the practitioner will maintain auditable records of the actual itemized invoice cost of the drug, including the numbers of doses of the drug represented on the invoice. New York State Medicaid does not intend to pay more than the acquisition cost of the drug dosage, as established by invoice, to the practitioner. Regardless of whether an invoice must be submitted to Medicaid for payment, the practitioner is expected to limit his or her Medicaid claim amount to the actual invoice cost of the drug dosage administered.
11. PRIOR APPROVAL:
Payment for those listed procedures where the MMIS code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.

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

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

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

14. RECEIPT OF HYSTERECTOMY INFORMATION:
Hysterectomies must not be performed for the purpose of sterilization. When hysterectomy procedures are performed and in all cases when procedures identified by MMIS codes 51925, 58150, 58152, 58180, 58200, 58205, 58210, 58240, 58260, 58262, 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. BILLING GUIDELINES:
For additional general billing guidelines see the current CPT manual.

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

-50 Bilateral Procedure (Surgical): Unless otherwise identified in the listings, bilateral surgical procedures requiring a separate incision that are performed at the same operative session, should be identified by the appropriate five digit code describing the first procedure. To indicate a bilateral surgical procedure was done add modifier -50 to the procedure number. (Reimbursement will not exceed 150% of the maximum Fee Schedule amount. One claim
line is to be billed representing the bilateral procedure. Amount billed should reflect total amount due.)

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

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

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

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

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

-79 Unrelated Procedure or Service by the Same Practitioner During the Postoperative Period: The practitioner may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be
reported by adding the modifier -79. (Reimbursement will not exceed 100% of the maximum Fee Schedule amount.)

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

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

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

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

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

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

### GENERAL

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>10021</td>
<td>Fine needle aspiration biopsy, without imaging guidance; first lesion</td>
</tr>
<tr>
<td>10004</td>
<td>each additional lesion (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>10005</td>
<td>Fine needle aspiration biopsy, including ultrasound guidance; first lesion</td>
</tr>
<tr>
<td>10006</td>
<td>each additional lesion (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>10007</td>
<td>Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion</td>
</tr>
<tr>
<td>10008</td>
<td>each additional lesion (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>10009</td>
<td>Fine needle aspiration biopsy, including CT guidance; first lesion</td>
</tr>
<tr>
<td>10010</td>
<td>each additional lesion (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>10011</td>
<td>Fine needle aspiration biopsy, including MR guidance; first lesion</td>
</tr>
<tr>
<td>10012</td>
<td>each additional lesion (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

### INTERGUMENTARY SYSTEM

#### SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES

#### INCISION AND DRAINAGE

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

#### EXCISION – DEBRIDEMENT

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<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>11000</td>
<td>Debridement of extensive eczematous or infected skin; up to 10% of body surface</td>
</tr>
</tbody>
</table>
| 11001  | each additional 10% of the body surface, or part thereof  
(List separately in addition to primary procedure)  
(Use 11001 in conjunction with 11000) |
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11004</td>
<td>Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum</td>
</tr>
<tr>
<td>11005</td>
<td>abdominal wall, with or without fascial closure</td>
</tr>
<tr>
<td>11006</td>
<td>external genitalia, perineum and abdominal wall, with or without fascial closure</td>
</tr>
<tr>
<td>11008</td>
<td>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)</td>
</tr>
<tr>
<td>11010</td>
<td>Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues</td>
</tr>
<tr>
<td>11011</td>
<td>skin, subcutaneous tissue, muscle fascia, and muscle</td>
</tr>
<tr>
<td>11012</td>
<td>skin, subcutaneous tissue, muscle fascia, muscle, and bone</td>
</tr>
<tr>
<td>11042</td>
<td>Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less</td>
</tr>
<tr>
<td>11043</td>
<td>Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less</td>
</tr>
<tr>
<td>11044</td>
<td>Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle, and/or fascia, if performed); first 20 sq cm or less</td>
</tr>
<tr>
<td>11045</td>
<td>Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to primary procedure) (Use 11045 in conjunction with 11042)</td>
</tr>
<tr>
<td>11046</td>
<td>Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to primary procedure) (Use 11046 in conjunction with 11043)</td>
</tr>
<tr>
<td>11047</td>
<td>Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle, and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to primary procedure) (Use 11047 in conjunction with 11044)</td>
</tr>
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**PARING OR CUTTING**

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<tbody>
<tr>
<td>11055</td>
<td>Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion</td>
</tr>
<tr>
<td>11056</td>
<td>two to four lesions</td>
</tr>
<tr>
<td>11057</td>
<td>more than four lesions</td>
</tr>
</tbody>
</table>

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

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

REMOVAL OF SKIN TAGS

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

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

SHAVING OF EPIDERMAL OR DERMAL LESIONS

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

11300   Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm. or less
11301   lesion diameter 0.6 to 1.0 cm
11302   lesion diameter 1.1 to 2.0 cm
11303   lesion diameter over 2.0 cm
11305   Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
11306   lesion diameter 0.6 to 1.0 cm
11307   lesion diameter 1.1 to 2.0 cm
11308 lesion diameter over 2.0 cm
11310 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
11311 lesion diameter 0.6 to 1.0 cm
11312 lesion diameter 1.1 to 2.0 cm
11313 lesion diameter over 2.0 cm

**EXCISION – BENIGN LESIONS**

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

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

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

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

11400 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401 excised diameter 0.6 to 1.0 cm
11402 excised diameter 1.1 to 2.0 cm
11403 excised diameter 2.1 to 3.0 cm
11404 excised diameter 3.1 to 4.0 cm
11406 excised diameter over 4.0 cm
11420 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421 excised diameter 0.6 to 1.0 cm
11422 excised diameter 1.1 to 2.0 cm
11423 excised diameter 2.1 to 3.0 cm
11424 excised diameter 3.1 to 4.0 cm
11426 excised diameter over 4.0 cm
11440 Excision, other benign lesion including margins, (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441 excised diameter 0.6 to 1.0 cm
11442 excised diameter 1.1 to 2.0 cm
11443 excised diameter 2.1 to 3.0 cm
Excision (including simple closure) of malignant lesions of skin (e.g., 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 (e.g., 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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>11604</td>
<td>Excision, diameter 3.1 to 4.0 cm</td>
</tr>
<tr>
<td>11606</td>
<td>Excision, diameter over 4.0 cm</td>
</tr>
<tr>
<td>11620</td>
<td>Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less</td>
</tr>
<tr>
<td>11621</td>
<td>Excision, diameter 0.6 to 1.0 cm</td>
</tr>
<tr>
<td>11622</td>
<td>Excision, diameter 1.1 to 2.0 cm</td>
</tr>
<tr>
<td>11623</td>
<td>Excision, diameter 2.1 to 3.0 cm</td>
</tr>
<tr>
<td>11624</td>
<td>Excision, diameter 3.1 to 4.0 cm</td>
</tr>
<tr>
<td>11626</td>
<td>Excision, diameter over 4.0 cm</td>
</tr>
<tr>
<td>11640</td>
<td>Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less</td>
</tr>
<tr>
<td>11641</td>
<td>Excision, diameter 0.6 to 1.0 cm</td>
</tr>
<tr>
<td>11642</td>
<td>Excision, diameter 1.1 to 2.0 cm</td>
</tr>
<tr>
<td>11643</td>
<td>Excision, diameter 2.1 to 3.0 cm</td>
</tr>
<tr>
<td>11644</td>
<td>Excision, diameter 3.1 to 4.0 cm</td>
</tr>
<tr>
<td>11646</td>
<td>Excision, diameter over 4.0 cm</td>
</tr>
<tr>
<td>11720</td>
<td>Debridement of nail(s) by any method(s); one to five</td>
</tr>
<tr>
<td>11721</td>
<td>Six or more</td>
</tr>
<tr>
<td>11730</td>
<td>Avulsion of nail plate, partial or complete, simple; single</td>
</tr>
<tr>
<td>11732</td>
<td>Each additional nail plate</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 11732 in conjunction with 11730)</td>
</tr>
<tr>
<td>11740</td>
<td>Evacuation of subungual hematoma</td>
</tr>
<tr>
<td>11750</td>
<td>Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;</td>
</tr>
<tr>
<td>11755</td>
<td>Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)</td>
</tr>
<tr>
<td>11760</td>
<td>Repair of nail bed</td>
</tr>
<tr>
<td>11762</td>
<td>Reconstruction of nail bed with graft</td>
</tr>
<tr>
<td>11765</td>
<td>Wedge excision of skin of nail fold (eg, for ingrown toenail)</td>
</tr>
<tr>
<td></td>
<td><strong>PILONIDAL CYST</strong></td>
</tr>
<tr>
<td>11770</td>
<td>Excision of pilonidal cyst or sinus; simple</td>
</tr>
<tr>
<td>11771</td>
<td>Extensive</td>
</tr>
<tr>
<td>11772</td>
<td>Complicated</td>
</tr>
<tr>
<td></td>
<td><strong>INTRODUCTION</strong></td>
</tr>
<tr>
<td>11900</td>
<td>Injection, intralesional; up to and including seven lesions</td>
</tr>
<tr>
<td>11901</td>
<td>More than seven lesions</td>
</tr>
<tr>
<td></td>
<td>(11900, 11901 are not to be used for preoperative local anesthetic injection)</td>
</tr>
<tr>
<td>11920</td>
<td>Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less</td>
</tr>
</tbody>
</table>
11921 6.1 to 20.0 sq cm
11922 each additional 20.0 sq cm, or part thereof
   (List separately in addition to primary procedure)
   (Use 11922 in conjunction with 11921)

11950 Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951 1.1 to 5 cc
11952 5.1 to 10 cc
11954 over 10 cc

11960 Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970 Replacement of tissue expander with permanent prosthesis
11971 Removal of tissue expander(s) without insertion of prosthesis
11976 Removal, implantable contraceptive capsules

11980 Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone
   pellets beneath the skin)
11981 Insertion, non-biodegradable drug delivery implant
11982 Removal, non-biodegradable drug delivery implant
11983 Removal with reinsertion, non-biodegradable drug delivery implant

REPAIR (CLOSURE)

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

DEFINITIONS:

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

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

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

COMPLEX REPAIR: includes the repairs of wounds requiring more than layered closure, viz., scar
revision, debridement, (eg, traumatic lacerations or avulsions), extensive undermining, stents or
retention sutures. Necessary preparation includes creation of a defect for repairs (eg, excision of a
scar requiring a complex repair) or the debridement of complicated lacerations or avulsions. Complex
repair does not include excision of benign (11400-11446) or malignant (11600-11646) lesions.

Instructions for listing services at time of wound repair:
1. The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular or stellate.

2. When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and from all anatomic sites that are grouped together into the same code descriptor. For example, add together the lengths of intermediate repairs to the trunk and extremities. Do not add lengths of repairs from different groupings of anatomic sites (eg, face and extremities). Also, do not add together lengths of different classifications (eg, intermediate and complex repairs).

3. Decontamination and/or debridement: Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure. (For extensive debridement of soft tissue and/or bone, see 11044) (For extensive debridement of soft tissue and/or bone, not associated with open fracture(s) and/or dislocation(s) resulting from penetrating and/or blunt trauma, see 11044.) (For extensive debridement of subcutaneous tissue, muscle fascia, muscle, and/or bone associated with open fracture(s) and/or dislocation(s), see 11010-11012.)

4. Involvement of nerves, blood vessels and tendons: Report under appropriate system (Nervous, Cardiovascular, Musculoskeletal) for repair of these structures. The repair of these associated wounds is included in the primary procedure. Simple ligation of vessels in an open wound is considered as part of any wound closure. Simple exploration of nerves, blood vessels or tendons exposed in an open wound is also considered part of the essential treatment of the wound and is not a separate procedure unless appreciable dissection is required. If the wound requires enlargement, extension of dissection (to determine penetration), debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s), of the subcutaneous tissue, muscle, fascia, and/or muscle, not requiring thoracotomy or laparotomy, use codes 20100-20103, as appropriate.

**REPAIR-SIMPLE**

12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
12002 2.6 cm to 7.5 cm
12004 7.6 cm to 12.5 cm
12005 12.6 cm to 20.0 cm
12006 20.1 cm to 30.0 cm
12007 over 30.0 cm
12011 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12013 2.6 cm to 5.0 cm
12014 5.1 cm to 7.5 cm
12015 7.6 cm to 12.5 cm
12016 12.6 cm to 20.0 cm
12017 20.1 cm to 30.0 cm
12018 over 30.0 cm
12020 Treatment of superficial wound dehiscence; simple closure

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

**REPAIR-COMPLEX**

13100  Repair, complex, trunk; 1.1 cm to 2.5 cm
13101  2.6 cm to 7.5 cm
13102  each additional 5 cm or less
(List separately in addition to primary procedure)
(Use 13102 in conjunction with 13101)
13120  Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121  2.6 cm to 7.5 cm
13122  each additional 5 cm or less
(List separately in addition to primary procedure)
(Use 13122 in conjunction with 13121)
13131  Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132  2.6 cm to 7.5cm
13133  each additional 5 cm or less
(List separately in addition to primary procedure)
(Use 13133 in conjunction with 13132)
13151  Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm
13152  2.6 cm to 7.5 cm
13153  each additional 5 cm or less
(List separately in addition to primary procedure)
(Use 13153 in conjunction with 13152)
13160  Secondary closure of surgical wound or dehiscence, extensive or complicated
**ADJACENT TISSUE TRANSFER OR REARRANGEMENT**

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

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

- **14000** Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
- **14001** defect 10.1 sq cm to 30.0 sq cm
- **14002**
- **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
- **14062**
- **14300**
- **14301** Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
- **14302** each additional 30.0 sq cm, or part thereof
  (List separately in addition to code)
  (Use 14302 in conjunction with 14301)
- **14350** Filleted finger or toe flap, including preparation of recipient site

**SKIN REPLACEMENT SURGERY**

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

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

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

Codes 15002 and 15005 describe burn and wound preparation or incisional or excisional release of scar contracture resulting in an open wound requiring a skin graft. Code 15100 describe the application of skin replacements and skin substitutes. The following definition should be applied to those codes that reference “100 sq cm or one percent of body area of infants and children” when determining the involvement of body size: The measurement of 100 sq cm is applicable to adults and children age 10 and over, percentages of body surface area apply to infants and children under the age of 10.
These codes are not intended to be reported for simple graft application alone or application stabilized with dressings (eg, simple gauze wrap) without surgical fixation of the skin substitute/graft. The skin substitute/graft is anchored using the surgeon’s choice of fixation. When services are performed in the office, the supply of the skin substitute/graft should be reported separately. Routine dressing supplies are not reported separately.

SURGICAL PREPARATION

15002 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children
15003 each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children
   (List separately in addition to primary procedure)
   (Use 15003 in conjunction with 15002)
15004 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children
15005 each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children
   (List separately in addition to primary procedure)
   (Use 15005 in conjunction with 15004)
   (Report 15002-15005 in conjunction with code for appropriate skin grafts or replacements [15050-15261], List the graft or replacement separately by its procedure number when the graft, immediate or delayed, is applied)

AUTOGRRAFT/TISSUE CULTURED AUTOGRRAFT

15040 Harvest of skin for tissue cultured skin autograft, 100 sq cm or less
15050 Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter
15100 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)
15101 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
   (List separately in addition to primary procedure)
   (Use 15101 in conjunction with 15100)
15110 Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children
15111 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
   (List separately in addition to primary procedure)
   (Use 15111 in conjunction with 15110)
15115 Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children
15116 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
   (List separately in addition to primary procedure)
   (Use 15116 in conjunction with 15115)

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

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

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

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

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

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

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

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

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

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

15156 additional 1 sq cm to 75 sq cm
   (List separately in addition to primary procedure)
   (Do not report 15156 more than once per session)
   (Use 15156 in conjunction with 15155)

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

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

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

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

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

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

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

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

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

SKIN SUBSTITUTE GRAFTS

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

15272 each additional 25 sq cm wound surface area, or part thereof
(List separately in addition to primary procedure)
(Use 15272 in conjunction with 15271)
(Do not report 15271, 15272 in conjunction with 15273, 15274)

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

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

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

15276 each additional 25 sq cm wound surface area, or part thereof
(List separately in addition to primary procedure)
(Use 15276 in conjunction with 15275)
(Do not report 15275, 15276 in conjunction with 15277, 15278)

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

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

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

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

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

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

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

OTHER FLAPS AND GRAFTS

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

15740 Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel
15750 neurovascular pedicle
15756 Free muscle or myocutaneous flap with microvascular anastomosis
15757 Free skin flap with microvascular anastomosis
15758 Free fascial flap with microvascular anastomosis
15760 Graft; composite (full thickness of external ear or nasal ala), including primary closure, donor area
15770 derma-fat-fascia
15775 Punch graft for hair transplant; 1 to 15 punch grafts
15776 more than 15 punch grafts
Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk)
(List separately in addition to primary procedure)
(For bilateral breast procedure, report 15777 with modifier 50)

OTHER PROCEDURES

15780 Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781 segmental, face
15782 regional, other than face
15783 superficial, any site, (eg, tattoo removal)
15786 Abrasion; single lesion (eg, keratosis, scar)
15787 each additional four lesions or less
(List separately in addition to primary procedure)
(Use 15787 in conjunction with 15786)
15788 Chemical peel, facial; epidermal
dermal
15792 Chemical peel, nonfacial; epidermal
dermal
15819 Cervicoplasty
15820 Blepharoplasty, lower eyelid;
15821 with extensive herniated fat pad
15822 Blepharoplasty, upper eyelid;
15823 with excessive skin weighting down lid
(For bilateral blepharoplasty, add modifier 50)
15824 Rhytidectomy; forehead
(For bilateral rhytidectomy, add modifier 50)
15825 neck with platysmal tightening (platysmal flap, P-flap)
15826 glabellar frown lines
15828 cheek, chin, and neck
15829 superficial musculoaponeurotic system (SMAS) flap
15830 Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
(Do not report 15830 in conjunction with 12031, 12032, 12034, 12035, 12036, 12037, 13100, 13101, 13102, 14000-14001, 14302)
15832 thigh
15833 leg
15834 hip
15835 buttock
15836 arm
15837 forearm or hand
15838 submental fat pad
15839 other area
(For bilateral procedure, add modifier 50)
15840 Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)
(For bilateral procedure, add modifier 50)

15841 free muscle graft (including obtaining graft)
15842 free muscle flap by microsurgical technique
15845 regional muscle transfer
15847 Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
(List separately in addition to primary procedure)
(Use 15847 in conjunction with 15830)

15851 Removal of sutures under anesthesia (other than local), other surgeon
15852 Dressing change (for other than burns) under anesthesia (other than local) (See Rule 4)
15860 Intravenous injection of agent (eg, fluorescein) to test vascular flow in flap or graft
15876 Suction assisted lipectomy; head and neck
15877 trunk
15878 upper extremity
15879 lower extremity

PRESSURE ULCERS (DECUBITIS ULCERS)

15920 Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture
15922 with flap closure
15931 Excision, sacral pressure ulcer, with primary suture;
15933 with ostectomy
15934 Excision, sacral pressure ulcer, with skin flap closure
15935 with ostectomy
15936 Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;
15937 with ostectomy
15940 Excision, ischial pressure ulcer, with primary suture;
15941 with ostectomy
15944 Excision, ischial pressure ulcer, with skin flap closure;
15945 with ostectomy
15946 Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin graft closure
15950 Excision, trochanteric pressure ulcer, with primary suture;
15951 with ostectomy
15952 Excision, trochanteric pressure ulcer, with skin flap closure;
15953 with ostectomy
15956 Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;
15958 with ostectomy
15999 Unlisted procedure, excision pressure ulcer

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

List percentage of body surface involved and depth of burn.

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

**DESTRUCTION**

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

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

**DESTRUCTION, BENIGN OR PREMALIGNANT LESIONS**

17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettlement), premalignant lesions (e.g., actinic keratoses); first lesion
17003 second through 14 lesions, each
(List separately in addition to code for first lesion)
(Use 17003 in conjunction with 17000)
17004 15 or more lesions
(Do not report 17004 in addition to 17000 – 17003)
17106 Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
17107 10.0 - 50.0 sq cm
17108 over 50.0 sq cm
17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettlement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111 15 or more lesions
17250 Chemical cauterization of granulation tissue (ie,proud flesh)

**DESTRUCTION, MALIGNANT LESIONS, ANY METHOD**

17260 Destruction, malignant lesion, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettlement), trunk, arms or legs; lesion diameter 0.5 cm or less
17261 lesion diameter 0.6 to 1.0 cm
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>17262</td>
<td>lesion diameter 1.1 to 2.0 cm</td>
</tr>
<tr>
<td>17263</td>
<td>lesion diameter 2.1 to 3.0 cm</td>
</tr>
<tr>
<td>17264</td>
<td>lesion diameter 3.1 to 4.0 cm</td>
</tr>
<tr>
<td>17266</td>
<td>lesion diameter over 4.0 cm</td>
</tr>
<tr>
<td>17270</td>
<td>Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemo-surgery, surgical curettage), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less</td>
</tr>
<tr>
<td>17271</td>
<td>lesion diameter 0.6 to 1.0 cm</td>
</tr>
<tr>
<td>17272</td>
<td>lesion diameter 1.1 to 2.0 cm</td>
</tr>
<tr>
<td>17273</td>
<td>lesion diameter 2.1 to 3.0 cm</td>
</tr>
<tr>
<td>17274</td>
<td>lesion diameter 3.1 to 4.0 cm</td>
</tr>
<tr>
<td>17276</td>
<td>lesion diameter over 4.0 cm</td>
</tr>
<tr>
<td>17280</td>
<td>Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemo-surgery, surgical curettage), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less</td>
</tr>
<tr>
<td>17281</td>
<td>lesion diameter 0.6 to 1.0 cm</td>
</tr>
<tr>
<td>17282</td>
<td>lesion diameter 1.1 to 2.0 cm</td>
</tr>
<tr>
<td>17283</td>
<td>lesion diameter 2.1 to 3.0 cm</td>
</tr>
<tr>
<td>17284</td>
<td>lesion diameter 3.1 to 4.0 cm</td>
</tr>
<tr>
<td>17286</td>
<td>lesion diameter over 4.0 cm</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17311</td>
<td>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) (e.g., 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</td>
</tr>
<tr>
<td>17312</td>
<td>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)</td>
</tr>
<tr>
<td>17313</td>
<td>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) (e.g., hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks</td>
</tr>
<tr>
<td>17314</td>
<td>each additional stage after the first stage, up to 5 tissue blocks</td>
</tr>
</tbody>
</table>

Version 2019
(List separately in addition to primary procedure)
(Use 17314 in conjunction with 17313)

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

OTHER PROCEDURES

17340 Cryotherapy (CO2 slush, liquid N2) for acne
17360 Chemical exfoliation for acne (eg, acne paste, acid)
17380 Electrolysis epilation, each 30 minutes
17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue

BREAST

INCISION

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

EXCISION

(To report bilateral procedures, use modifier -50)

Excisional breast surgery includes certain biopsy procedures, the removal of cysts or other benign or malignant tumors or lesions, and the surgical treatment of breast and chest wall malignancies. Biopsy procedures may be percutaneous or open, and they involve the removal of differing amounts of tissue for diagnosis.

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

Partial mastectomy procedures are reported using codes 19301 or 19302 as appropriate. Documentation for partial mastectomy procedures includes attention to the removal of adequate surgical margins surrounding the breast mass or lesion.
Total mastectomy procedures include simple mastectomy, complete mastectomy, subcutaneous mastectomy, modified radical mastectomy, radical mastectomy, and more extended procedures (eg, Urban type operation). Total mastectomy procedures are reported using codes 19303-19307 as appropriate.

Excisions or resections of chest wall tumors including ribs, with or without reconstruction, with or without mediastinal lymphadenectomy, are reported using codes 19260, 19271, or 19272. Codes 19260-19272 are not restricted to breast tumors and are used to report resections of chest wall tumors originating from any chest wall component.

19081 Biopsy, breast, with placement of breast localization devices(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance
19082 each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)
19083 Biopsy, breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance
19084 each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)
19085 Biopsy, breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance
19086 each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)
19100 Biopsy of breast; percutaneous, needle core, not using needle guidance (separate procedure)
19101 open, incisional
19105 Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma (Do not report 19105 in conjunction with 76940, 76942)
19110 Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct
19112 Excision of lactiferous duct fistula
19120 Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, one or more lesions
19125 Excision of breast lesion identified by pre-operative placement of radiological marker, open; single lesion
19126 each additional lesion separately identified by a preoperative radiological marker (List separately in addition to primary procedure) (Use 19126 in conjunction with code 19125)
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

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

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

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

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

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

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

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

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

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

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

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

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

MASTECTOMY PROCEDURES

19300 Mastectomy for gynecomastia

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

19302 Mastectomy, simple, complete

19303 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
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
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
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
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

OTHER PROCEDURES

19499 Unlisted procedure, breast

MUSCULOSKELETAL SYSTEM

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

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

DEFINITIONS:

The terms "closed treatment", "open treatment" and "percutaneous skeletal fixation" have been carefully chosen to accurately reflect current orthopedic procedural treatments.
CLOSED TREATMENT - specifically means that the fracture site is not surgically opened (exposed to the external environment and directly visualized). This terminology is used to describe procedures that treat fractures by three methods: 1) without manipulation; 2) with manipulation; or 3) with or without traction.

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL

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

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

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

**EXCISION**

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

**INTRODUCTION OR REMOVAL**

20500 Injection of sinus tract; therapeutic (separate procedure)
20501 diagnostic (sinogram)
20520 Removal of foreign body in muscle, or tendon sheath, simple
20525 deep or complicated
20526 Injection, therapeutic (eg, local anesthetic; corticosteroid), carpal tunnel
20527 Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren’s contracture)
20550 Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")
20551 single tendon origin/insertion
20552 single or multiple trigger point(s), one or two muscle(s)
20553 single or multiple trigger point(s), three or more muscle(s)
20555 Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)
20600  Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance
20604  with ultrasound guidance, with permanent recording and reporting
20605  Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, tempomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance
20606  with ultrasound guidance, with permanent recording and reporting
20610  Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
20611  with ultrasound guidance, with permanent recording and reporting
20612  Aspiration and/or injection of ganglion cyst(s) any location
20615  Aspiration and injection for treatment of bone cyst
20650  Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)
20660  Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)
20661  Application of halo, including removal; cranial
20662         pelvic
20663         femoral
20664  Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta)
20665  Removal of tongs or halo applied by another individual
20670  Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)
20680         deep, (eg, buried wire, pin, screw, metal band, nail, rod or plate)
20690  Application of a uniplane (pins or wires in one plane), unilateral, external fixation system
20692  Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)
20693  Adjustment or revision of external fixation system requiring anesthesia (eg, new pin(s) or wire(s), and/or new ring(s) or bar(s))
20694  Removal, under anesthesia, of external fixation system

REPLANTATION
20802  Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation
20805  Replantation, forearm, (includes radius and ulna to radial carpal joint), complete amputation
20808  Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation
20816  Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation
20822  Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation
20824  Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputation
20827  Replantation, thumb (includes distal tip to MP joint), complete amputation
20838  Replantation, foot, complete amputation
GRAFTS (OR IMPLANTS)

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

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

20900  Bone graft, any donor area; minor or small (eg, dowel or button)
20902   major or large
20910  Cartilage graft; costochondral
20912    nasal septum
20920  Fascia lata graft; by stripper
20922    by incision and area exposure, complex or sheet
20924  Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)
20926  Tissue grafts, other (eg, paratenon, fat, dermis)
20931  Allograft, structural, for spine surgery only
   (List separately in addition to primary procedure)
20932  Allograft, includes templating, cutting, placement and internal fixation, when performed; osteoarticular including articular surface and contiguous bone (List separately in addition to primary procedure)
20933   hemicortical intercalary, partial (ie, hemicylindrical) (List separately in addition to primary procedure)
20934   intercalary, complete (ie, cylindrical) (List separately in addition to primary procedure)
20937   morselized (through separate skin or fascial incision)
   (List separately in addition to primary procedure)
20938   structural, bicortical or tricortical (through separate skin or fascial incision)
   (List separately in addition to code for primary procedure)
20939   Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in additional to code for primary procedure)

OTHER PROCEDURES

20950  Monitoring of interstitial fluid pressure (includes insertion of device eg, wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome
20955  Bone graft with microvascular anastomosis; fibula
20956    iliac crest
20957    metatarsal
20962    other than fibula, iliac crest, or metatarsal
20969  Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe
20970    iliac crest
20972    metatarsal
20973    great toe with web space
20974# Electrical stimulation to aid bone healing; noninvasive (nonoperative)
20975    invasive (operative)
20979# Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)

20982 Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency

20999 Unlisted procedure, musculoskeletal system, general

**HEAD**

Skull, facial bones and temporomandibular joint.

**INCISION**

21010 Arthrotomy, temporomandibular joint

(To report bilateral procedures, use modifier -50)

**EXCISION**

21011 Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm
21012 2 cm or greater
21013 Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm
21014 2 cm or greater
21015 Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm
21016 2 cm or greater
21025 Excision of bone (eg, for osteomyelitis or bone abscess); mandible
21026  
21029 Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)
21030 Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage
21031 Excision of torus mandibularis
21032 Excision of maxillary torus palatinus
21034 Excision of malignant tumor of maxilla or zygoma
21040 Excision of benign tumor or cyst of mandible, by enucleation and/or curettage
21044 Excision of malignant tumor of mandible;
21045  
21046 Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))
21047  requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))
21048 Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))
21049  requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))
21050 Condylectomy, temporomandibular joint; (separate procedure)

(For bilateral procedures use modifier -50)
21060 Meniscectomy, partial or complete, temporomandibular joint (separate procedure)

(For bilateral procedures use modifier -50)
21070 Coronoidectomy (separate procedure)
(For bilateral procedures use modifier -50)

MANIPULATION

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

HEAD PROSTHESIS

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

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

INTRODUCTION OR REMOVAL

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

REPAIR, REVISION, AND/OR RECONSTRUCTION

21120  Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121   sliding osteotomy, single piece
21122   sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123   sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125   Augmentation, mandibular body or angle; prosthetic material
21127   with bone graft, onlay or interpositional (includes obtaining autograft)
21137   Reduction forehead; contouring only
contouring and application of prosthetic material or bone graft (includes obtaining autograft)
contouring and setback of anterior frontal sinus wall
Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
two pieces, segment movement in any direction, without bone graft
three or more pieces, segment movement in any direction, without bone graft
single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome) any direction, requiring bone grafts (includes obtaining autografts)
Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I
Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial
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
Reconstruction of mandibular rami, horizontal, vertical, "C", or "L" osteotomy; without bone graft
Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
Osteotomy, mandible, segmental;
21199 with genioglossus advancement
21206 Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)
21208 Osteoplasty, facial bones; augmentation (autograft, allograft or prosthetic implant)
21209 reduction
21210 Graft, bone; nasal, maxillary and malar areas (includes obtaining graft)
21211 mandible (includes obtaining graft)
21230 Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235 ear cartilage, autograft, to nose or ear (includes obtaining graft)
21240 Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
21242 Arthroplasty, temporomandibular joint, with allograft
21243 Arthroplasty, temporomandibular joint, with prosthetic joint replacement
21244 Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
21245 Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246 complete
21247 Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
21248 Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
21249 complete
21255 Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256 Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)
21260 Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261 combined intra- and extracranial approach
21263 with forehead advancement
21267 Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268 combined intra- and extracranial approach
21270 Malar augmentation, prosthetic material
21275 Secondary revision of orbitocraniofacial reconstruction
21280 Medial canthopexy (separate procedure)
21282 Lateral canthopexy
21295 Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach
21296 intraoral approach

OTHER PROCEDURES

21299 Unlisted craniofacial and maxillofacial procedure

FRACTURE AND/OR DISLOCATION

21310 Closed treatment of nasal bone fracture without manipulation
21315 Closed treatment, nasal bone fracture; without stabilization
21320 with stabilization
21325 Open treatment of nasal fracture; uncomplicated
21330 complicated, with internal and/or external skeletal fixation
21335 with concomitant open treatment of fractured septum
21336 Open treatment of nasal septal fracture, with or without stabilization
21337 Closed treatment of nasal septal fracture, with or without stabilization
21338 Open treatment of nasoethmoid fracture; without external fixation
21339 with external fixation
21340 Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus
21343 Open treatment of depressed
21344 Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches
21345 Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint
21346 Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation
21347 requiring multiple open approaches
21348 with bone grafting (includes obtaining graft)
21355 Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation
21356 Open treatment of depressed zygomatic arch fracture (eg, Gilles approach)
21360 Open treatment of depressed malar fracture, including zygomatic arch and malar tripod
21365 Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches
21366 with bone grafting (includes obtaining graft)
21385 Open treatment of orbital floor blowout fracture; transantral approach (Caldwell Luc type operations)
21386 periorbital approach
21387 combined approach
21390 periorbital approach, with alloplastic or other implant
21395 periorbital approach with bone graft (includes obtaining graft)
21400 Closed treatment of fracture of orbit, except blowout; without manipulation
21401 with manipulation
21406 Open treatment of fracture of orbit except blowout; without implant
21407 with implant
21408 with bone grafting (includes obtaining graft)
21421 Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint
21422 Open treatment of palatal or maxillary fracture (LeFort I type);
21423 complicated (comminuted or involving cranial nerve foramina), multiple approaches
21431 Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint
21432 Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation
21433 complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches
21435 complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation)
21436 complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)
21440 Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21445 Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21450 Closed treatment of mandibular fracture; without manipulation
21451 with manipulation
21452 Percutaneous treatment of mandibular fracture, with external fixation
21453 Closed treatment of mandibular fracture with interdental fixation
21454 Open treatment of mandibular fracture with external fixation
21461 Open treatment of mandibular fracture; without interdental fixation
21462 with interdental fixation
21465 Open treatment of mandibular condylar fracture
21470 Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints
21480 Closed treatment of temporomandibular dislocation, initial or subsequent
21485 complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent
21490 Open treatment of temporomandibular dislocation

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

NECK (SOFT TISSUES) AND THORAX

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

EXCISION
21550 Biopsy, soft tissue of neck or thorax
21552 Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater
21554 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater
21555 Excision tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm
21556 subfascial (eg, intramuscular); less than 5 cm
21557 Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm
21558 5 cm or greater
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21600</td>
<td>Excision of rib, partial</td>
</tr>
<tr>
<td>21610</td>
<td>Costotransversectomy (separate procedure)</td>
</tr>
<tr>
<td>21615</td>
<td>Excision first and/or cervical rib; with sympathectomy</td>
</tr>
<tr>
<td>21620</td>
<td>Ostectomy of sternum, partial</td>
</tr>
<tr>
<td>21627</td>
<td>Sternal debridement</td>
</tr>
<tr>
<td>21630</td>
<td>Radical resection of sternum; with mediastinal lymphadenectomy</td>
</tr>
<tr>
<td>21616</td>
<td>Excision first and/or cervical rib; with sympathectomy</td>
</tr>
<tr>
<td>21632</td>
<td>Radical resection of sternum; with mediastinal lymphadenectomy</td>
</tr>
<tr>
<td>21620</td>
<td>Ostectomy of sternum, partial</td>
</tr>
<tr>
<td>21630</td>
<td>Radical resection of sternum; with mediastinal lymphadenectomy</td>
</tr>
<tr>
<td>21632</td>
<td>Radical resection of sternum; with mediastinal lymphadenectomy</td>
</tr>
<tr>
<td>REPAIR, REVISION AND/OR RECONSTRUCTION</td>
<td></td>
</tr>
<tr>
<td>21685</td>
<td>Hyoid myotomy and suspension</td>
</tr>
<tr>
<td>21700</td>
<td>Division of scalenus anticus; without resection of cervical rib</td>
</tr>
<tr>
<td>21705</td>
<td>Division of scalenus anticus; with resection of cervical rib</td>
</tr>
<tr>
<td>21720</td>
<td>Division of sternocleidomastoid for torticollis, open operation; without cast application</td>
</tr>
<tr>
<td>21725</td>
<td>Division of sternocleidomastoid for torticollis, open operation; with cast application</td>
</tr>
<tr>
<td>21740</td>
<td>Reconstructive repair of pectus excavatum or carinatum; open</td>
</tr>
<tr>
<td>21742</td>
<td>Reconstructive repair of pectus excavatum or carinatum; with thoracoscopy</td>
</tr>
<tr>
<td>21743</td>
<td>Reconstructive repair of pectus excavatum or carinatum; without thoracoscopy</td>
</tr>
<tr>
<td>21750</td>
<td>Closure of median sternotomy separation with or without debridement (separate procedure)</td>
</tr>
<tr>
<td>FRACTURE AND/OR DISLOCATION</td>
<td></td>
</tr>
<tr>
<td>21811</td>
<td>Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs</td>
</tr>
<tr>
<td>21812</td>
<td>4-6 ribs</td>
</tr>
<tr>
<td>21813</td>
<td>7 or more ribs</td>
</tr>
<tr>
<td>21820</td>
<td>Closed treatment of sternum fracture</td>
</tr>
<tr>
<td>21825</td>
<td>Open treatment of sternum fracture with or without skeletal fixation</td>
</tr>
<tr>
<td>OTHER PROCEDURES</td>
<td></td>
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<tr>
<td>21899</td>
<td>Unlisted procedure, neck or thorax</td>
</tr>
<tr>
<td>BACK AND FLANK</td>
<td></td>
</tr>
<tr>
<td>EXCISION</td>
<td></td>
</tr>
<tr>
<td>21920</td>
<td>Biopsy, soft tissue of back or flank; superficial</td>
</tr>
<tr>
<td>21925</td>
<td>Biopsy, soft tissue of back or flank; deep</td>
</tr>
<tr>
<td>21930</td>
<td>Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm</td>
</tr>
<tr>
<td>21931</td>
<td>Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater</td>
</tr>
<tr>
<td>21932</td>
<td>Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm</td>
</tr>
<tr>
<td>21933</td>
<td>Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5 cm or greater</td>
</tr>
<tr>
<td>21935</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm</td>
</tr>
<tr>
<td>21936</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; 5 cm or greater</td>
</tr>
</tbody>
</table>
SPINE (VERTEBRAL COLUMN)

Cervical, thoracic, and lumbar spine.

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

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

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

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

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


INCISION

22010 Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic

22015 lumbar, sacral, or lumbosacral
(Do not report 22015 in conjunction with 22010)
(Do not report 22015 in conjunction with instrumentation removal, 10180, 22850, 22852)

EXCISION

For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of partial vertebral body excision, each surgeon should report his/her distinct operative work by appending the modifier –62 to the procedure code. In this situation, the modifier –62 may be appended to the procedure code(s) 22100-22102, 22110-22114 and, as appropriate, to the associated additional vertebral segment add-on code(s) 22103, 22116 as long as both surgeons continue to work together as primary surgeons.
22100 Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical
22101  thoracic
22102  lumbar
22103  each additional segment
   (List separately in addition to primary procedure)
   (Use 22103 in conjunction with codes 22100, 22101, 22102)
22110 Partial excision of vertebral body for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical
22112  thoracic
22114  lumbar
22116  each additional vertebral segment
   (List separately in addition to primary procedure)
   (Use 22116 only for codes 22110, 22112, 22114)

OSTEOTOMY

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

22206 Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic
   (Do not report 22206 in conjunction with 22207)
22207  lumbar
   (Do not report 22207 in conjunction with 22206)
22208  each additional vertebral segment
   (List separately in addition to primary procedure)
   (Use 22208 in conjunction with 22206, 22207)
   (Do not report 22206, 22207, 22208 in conjunction with 22210-22226, 22830, 63001-63048, 63055-63066, 63075-63091, 63101-63103, when performed at the same level)
22210 Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; cervical
22212  thoracic
22214  lumbar
22216  each additional segment
   (List separately in addition to primary procedure)
   (Use 22216 in conjunction with 22210, 22212, 22214)
22220 Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical
22222  thoracic
22224  lumbar
22226  each additional segment
   (List separately in addition to primary procedure)
(Use 22226 only for codes 22220, 22222, 22224)

**FRACTURE AND/OR DISLOCATION**

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

22310  Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing

22315  Closed treatment of vertebral fracture(s) and/or dislocation(s) requiring casting or bracing, with and including casting and/or bracing by manipulation or traction

22318  Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) including os odontoideum), anterior approach, including placement of internal fixation; without grafting

22319  with grafting

22325  Open treatment and/or reduction of vertebral fracture (s) and/or dislocation(s); posterior approach, one fractured vertebrae or dislocated segment; lumbar

22326  cervical

22327  thoracic

22328  each additional fractured vertebrae or dislocated segment

(List separately in addition to primary procedure)

(Use 22328 in conjunction with codes 22325, 22326, 22327)

**MANIPULATION**

22505  Manipulation of spine requiring anesthesia, any region

**PERCUTANEOUS VEREBROPLASTY and VERTEBRAL AUGMENTATION**

22510  Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic

22511  lumbosacral

22512  each additional cervicothoracic or lumbosacral vertebral body

(List separately in addition to code for primary procedure)

22513  Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic

22514  lumbar

22515  each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)
VERTEBRAL BODY, EMBOLIZATION OR INJECTION

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

ARTHRODESIS

LATERAL EXTRACAVITARY APPROACH TECHNIQUE

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

ANTERIOR OR ANTEROLATERAL APPROACH TECHNIQUE

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

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

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

22548  Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process
22551  Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552  cervical below C2, each additional interspace
        (List separately in addition to primary procedure)
22554  Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
22556  thoracic
22558  lumbar
22585  each additional interspace
        (List separately in addition to primary procedure)
(Use 22585 in conjunction with 22554, 22556, 22558)

22586  Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace

POSTERIOR, POSTEROLATERAL OR LATERAL TRANSVERSE PROCESS TECHNIQUE

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

22590  Arthrodesis, posterior technique, craniocervical (occiput-C2)
22595  Arthrodesis, posterior technique, atlas-axis (Cl-C2)
22600  Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment
22610   thoracic (with lateral transverse technique, when performed)
22612   lumbar (with lateral transverse technique, when performed)
22614   each additional vertebral segment
   (List separately in addition to primary procedure)
   (Use 22614 in conjunction with 22600, 22610, 22612)
22630  Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression) single interspace; lumbar
22632   each additional interspace
   (List separately in addition to primary procedure)
   (Use 22632 in conjunction with 22630)
22633  Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar
22634   each additional interspace and segment
   (List separately in addition to primary procedure)
   (Use 22634 in conjunction with 22633)

SPINE DEFORMITY (EG, SCOLIOSIS, KYPHOSIS)

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

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

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

EXPLORATION

22830 Exploration of spinal fusion

SPINAL INSTRUMENTATION

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

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

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

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

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

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

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

22840 Posterior non-segmental instrumentation (eg, Harrington Rod Technique), pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation (List separately in addition to primary procedure)
22842 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to primary procedure)
22843 7 to 12 vertebral segments (List separately in addition to primary procedure)
22844 13 or more vertebral segments
22845 Anterior instrumentation; 2 to 3 vertebral segments  
(List separately in addition to primary procedure)
22846  4 to 7 vertebral segments
22847  8 or more vertebral segments
22848 Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum  
(List separately in addition to primary procedure)
22849 Reinsertion of spinal fixation device
22850 Removal of posterior nonsegmental instrumentation (eg, Harrington rod)
22852 Removal of posterior segmental instrumentation
22853 Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
22854 Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial of complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
22859 Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate), to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
22855 Removal of anterior instrumentation
22856 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical
22858  second level, cervical (List separately in addition to code for primary procedure)
22857 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar
22861 Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22862  lumbar
22864 Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical  
(Do not report 22864 in conjunction with 22861)
22865 Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace, lumbar

OTHER PROCEDURES

22899 Unlisted procedure, spine
ABDOMEN

EXCISION

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

OTHER PROCEDURES

22999  Unlisted procedure, abdomen, musculoskeletal system

SHOULDER

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

INCISION

23000  Removal of subdeltoid calcareous deposits, open
23020  Capsular contracture release (eg, Sever type procedure)
23030  Incision and drainage, shoulder area; deep abscess or hematoma
23031  infected bursa
23035  Incision, bone cortex (eg, osteomyelitis or bone abscess), shoulder area
23040  Arthrotomy, glenohumeral joint, including exploration, drainage or removal of foreign body
23044  Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage or removal of foreign body

EXCISION

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

**INTRODUCTION OR REMOVAL**

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

**REPAIR, REVISION AND/OR RECONSTRUCTION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>23395</td>
<td>Muscle transfer, any type, shoulder or upper arm; single</td>
</tr>
<tr>
<td>23397</td>
<td>multiple</td>
</tr>
<tr>
<td>23400</td>
<td>Scapulopexy (eg, Sprengels deformity or for paralysis)</td>
</tr>
<tr>
<td>23405</td>
<td>Tenotomy, shoulder area; single tendon</td>
</tr>
<tr>
<td>23406</td>
<td>multiple tendons through same incision</td>
</tr>
<tr>
<td>23410</td>
<td>Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute</td>
</tr>
<tr>
<td>23412</td>
<td>chronic</td>
</tr>
<tr>
<td>23415</td>
<td>Coracoacromial ligament release, with or without acromioplasty</td>
</tr>
<tr>
<td>23420</td>
<td>Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)</td>
</tr>
<tr>
<td>23430</td>
<td>Tenodesis of long tendon of biceps</td>
</tr>
</tbody>
</table>
Physician - Procedure Codes, Section 5 - Surgery

23440  Resection or transplantation of long tendon of biceps
23450  Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation
23455   with labral repair (eg, Bankart procedure)
23460  Capsulorrhaphy, anterior, any type; with bone block
23462   with coracoid process transfer
23465  Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block
23466  Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
23470  Arthroplasty, glenohumeral joint; hemiarthroplasty
23472   total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)
23473  Revision of total shoulder arthroplasty, including allograft when performed; humeral or
   glenoid component
23474   humeral and glenoid component
23480  Osteotomy, clavicle, with or without internal fixation;
23485   with bone graft for nonunion or malunion (includes obtaining graft and/or necessary
   fixation)
23490  Prophylactic treatment (nailing, pinning, plating, or wiring) with or without
   methylmethacrylate; clavicle
23491   proximal humerus

FRACTURE AND/OR DISLOCATION

23500  Closed treatment of clavicular fracture; without manipulation
23505   with manipulation
23515  Open treatment of clavicular fracture, includes internal fixation, when performed
23520  Closed treatment of sternoclavicular dislocation; without manipulation
23525   with manipulation
23530  Open treatment of sternoclavicular dislocation, acute or chronic;
23532   with fascial graft (includes obtaining graft)
23540  Closed treatment of acromioclavicular dislocation; without manipulation
23545   with manipulation
23550  Open treatment of acromioclavicular dislocation, acute or chronic;
23552   with fascial graft (includes obtaining graft)
23570  Closed treatment of scapular fracture; without manipulation
23575   with manipulation, with or without skeletal traction (with or without shoulder joint
   involvement)
23585  Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation,
   when performed
23600  Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without
   manipulation
23605   with manipulation, with or without skeletal traction
23615  Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal
   fixation, when performed, includes repair of tuberosity(s), when performed;
23616   with proximal humeral prosthetic replacement
23620  Closed treatment of greater humeral tuberosity fracture; without manipulation
23625   with manipulation
23630 Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed
23650 Closed treatment of shoulder dislocation, with manipulation; without anesthesia
23655 requiring anesthesia
23660 Open treatment of acute shoulder dislocation
23665 Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation
23670 Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed
23675 Closed treatment of shoulder dislocation, with surgical or anatomical neck fracture, with manipulation
23680 Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed

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

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

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

OTHER PROCEDURES
23929 Unlisted procedure, shoulder

HUMERUS (UPPER ARM) AND ELBOW
Elbow area includes head and neck of radius and olecranon process.

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24065</td>
<td>Biopsy, soft tissue of upper arm or elbow area; superficial</td>
</tr>
<tr>
<td>24066</td>
<td>deep (subfascial or intramuscular)</td>
</tr>
<tr>
<td>24071</td>
<td>Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater</td>
</tr>
<tr>
<td>24073</td>
<td>Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater</td>
</tr>
<tr>
<td>24075</td>
<td>Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm</td>
</tr>
<tr>
<td>24076</td>
<td>Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm</td>
</tr>
<tr>
<td>24077</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; less than 5 cm</td>
</tr>
<tr>
<td>24079</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>24100</td>
<td>Arthrotomy, elbow; with synovial biopsy only</td>
</tr>
<tr>
<td>24101</td>
<td>with joint exploration, with or without biopsy, with or without removal of loose or foreign body</td>
</tr>
<tr>
<td>24102</td>
<td>with synovectomy</td>
</tr>
<tr>
<td>24105</td>
<td>Excision, olecranon bursa</td>
</tr>
<tr>
<td>24110</td>
<td>Excision or curettage of bone cyst or benign tumor, humerus;</td>
</tr>
<tr>
<td>24115</td>
<td>with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>24116</td>
<td>with allograft</td>
</tr>
<tr>
<td>24120</td>
<td>Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process;</td>
</tr>
<tr>
<td>24125</td>
<td>with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>24126</td>
<td>with allograft</td>
</tr>
<tr>
<td>24130</td>
<td>Excision, radial head</td>
</tr>
<tr>
<td>24134</td>
<td>Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus</td>
</tr>
<tr>
<td>24136</td>
<td>radial head or neck</td>
</tr>
<tr>
<td>24138</td>
<td>olecranon process</td>
</tr>
<tr>
<td>24140</td>
<td>Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis); humerus</td>
</tr>
<tr>
<td>24145</td>
<td>radial head or neck</td>
</tr>
<tr>
<td>24147</td>
<td>olecranon process</td>
</tr>
<tr>
<td>24149</td>
<td>Radical resection of capsule, soft tissue, and heterotopic bone, elbow, with contracture release (separate procedure)</td>
</tr>
<tr>
<td>24150</td>
<td>Radical resection of tumor, shaft or distal humerus</td>
</tr>
<tr>
<td>24152</td>
<td>Radical resection of tumor, radial head or neck</td>
</tr>
<tr>
<td>24155</td>
<td>Resection of elbow joint (arthrectomy)</td>
</tr>
</tbody>
</table>

### INTRODUCTION OR REMOVAL

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24160</td>
<td>Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components</td>
</tr>
<tr>
<td>24164</td>
<td>radial head</td>
</tr>
<tr>
<td>24200</td>
<td>Removal of foreign body, upper arm or elbow area; subcutaneous</td>
</tr>
<tr>
<td>24201</td>
<td>deep (subfascial or intramuscular)</td>
</tr>
</tbody>
</table>
24220  Injection procedure for elbow arthrography

**REPAIR, REVISION AND/OR RECONSTRUCTION**

24300  Manipulation, elbow, under anesthesia
24301  Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)
24305  Tendon lengthening, upper arm or elbow, each tendon
24310  Tenotomy, open, elbow to shoulder, each tendon
24320  Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single
       (Seddon-Brookes type procedure)
24330  Flexor-plasty, elbow, (eg, Steindler type advancement);
       with extensor advancement
24331  Tenolysis, triceps
24340  Repair lateral collateral ligament, elbow, with local tissue
24344  Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of
       graft)
24345  Repair medial collateral ligament, elbow, with local tissue
24346  Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of
       graft)
24357  Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow);
       percutaneous
24358  Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow);
       debridement, soft tissue and/or bone, open
24359  Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow);
       debridement, soft tissue and/or bone, open with tendon repair or reattachment
24360  Arthroplasty, elbow; with membrane (eg, fascial)
24361  with distal humeral prosthetic replacement
24362  with implant and fascia lata ligament reconstruction
24363  with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)
24365  Arthroplasty, radial head;
24366  with implant
24370  Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar
       component
24371  humeral and ulnar component
24400  Osteotomy, humerus, with or without internal fixation
24410  Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type
       procedure)
24420  Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876)
24430  Repair of nonunion or malunion, humerus; without graft (eg, compression technique, etc)
24435  with iliac or other autograft (includes obtaining graft)
24470  Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus)
24495  Decompression fasciotomy, forearm, with brachial artery exploration
24498  Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, humeral shaft

FRACTURE AND/OR DISLOCATION

24500  Closed treatment of humeral shaft fracture; without manipulation
24505   with manipulation, with or without skeletal traction
24515  Open treatment of humeral shaft fracture with plate/screws, with or without cerclage
24516  Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws
24530  Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; without manipulation
24535   with manipulation, with or without skin or skeletal traction
24538  Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension
24545  Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension
24546   with intercondylar extension
24560  Closed treatment of humeral epicondylar fracture, medial or lateral; without manipulation
24565   with manipulation
24566  Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation
24575  Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed
24576  Closed treatment of humeral condylar fracture, medial or lateral; without manipulation
24577   with manipulation
24579  Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed
24582  Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation
24586  Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius);
24587   with implant arthroplasty
   (See also 24361)
24600  Treatment of closed elbow dislocation; without anesthesia
24605   requiring anesthesia
24615  Open treatment of acute or chronic elbow dislocation
24620  Closed treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with manipulation
24635  Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed
24640  Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation
24650  Closed treatment of radial head or neck fracture; without manipulation
24655   with manipulation
24665  Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed;
24666  with radial head prosthetic replacement
24670  Closed treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process [es]); without manipulation
24675  with manipulation
24685  Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process [es]), includes internal fixation, when performed

ARTHRODESIS

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

AMPUTATION

24900  Amputation, arm through humerus; with primary closure
24920  open, circular (guillotine)
24925  secondary closure or scar revision
24930  re-amputation
24931  with implant
24935  Stump elongation, upper extremity
24940  Cineplasty, upper extremity, complete procedure

OTHER PROCEDURES

24999  Unlisted procedure, humerus or elbow

FOREARM AND WRIST

Radius, ulna, carpal bones and joints.

INCISION

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

25065  Biopsy, soft tissue; superficial
25066  deep (subfascial or intramuscular)
25071  Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater
25073  Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater
25075  Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm
25076  Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm
25077  Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; less than 3 cm
25078  3 cm or greater
25085  Capsulotomy, wrist (eg, for contracture)
25100  Arthrotomy, wrist joint; with biopsy
25101  with joint exploration, with or without biopsy, with or without removal of loose or foreign body
25105  with synovectomy
25107  Arthroty, distal radioulnar joint including repair of triangular cartilage, complex
25109  Excision of tendon, forearm and/or wrist, flexor or extensor, each
25110  Excision, lesion of tendon sheath
25111  Excision of ganglion, wrist (dorsal or volar); primary
25112  recurrent
25115  Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors
25116  extensors (with or without transposition of dorsal retinaculum)
25118  Synovectomy, extensor tendon sheath, wrist, single compartment;
25119  with resection of distal ulna
25120  Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process);
25125  with autograft (includes obtaining graft)
25126  with allograft
25130  Excision or curettage of bone cyst or benign tumor of carpal bones;
25135  with autograft (includes obtaining graft)
25136  with allograft
25145  Sequestrectomy (eg, for osteomyelitis or bone abscess)
25150  Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis); ulna
25151  radius
25170  Radical resection for tumor, radius or ulna
25210  Carpectomy; one bone
25215  all bones of proximal row
25230  Radial styloectomy (separate procedure)
25240  Excision distal ulna partial or complete (eg, Darrach type or matched resection)
INTRODUCTION OR REMOVAL

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

REPAIR, REVISION AND/OR RECONSTRUCTION

25260 Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle
25263 secondary, single, each tendon or muscle
25265 secondary, with free graft (includes obtaining graft) each tendon or muscle
25270 Repair, tendon or muscle, extensor; forearm and/or wrist; primary, single, each tendon or muscle
25272 secondary, single, each tendon or muscle
25274 secondary, with free graft (includes obtaining graft), each tendon or muscle
25275 Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for exterior carpi ulnaris subluxation)
25280 Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist; single, each tendon
25290 Tenotomy, open, flexor or extensor tendon, forearm and/or wrist single, each tendon
25295 Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon
25300 Tenodesis at wrist; flexors of fingers
25310 extensors of fingers
25310 Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon
25312 with tendon graft(s) (includes obtaining graft), each tendon
25315 Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist;
25316 with tendon(s) transfer
25320 Capsulorrhaphy or reconstruction, wrist, open, (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability
25332 Arthroplasty, wrist, with or without interposition, with or without external or internal fixation
25335 Centralization of wrist on ulna (eg, radial club hand)
25337 Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by soft tissue stabilization (eg, tendon transfer, tendon graft or weave, or tenodesis) with or without open reduction of distal radioulnar joint
25350 Osteotomy, radius; distal third
25355 middle or proximal third
25360 Osteotomy; ulna
25365 radius AND ulna
25370 Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna
25375 radius AND ulna
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25390</td>
<td>Osteoplasty, radius OR ulna; shortening</td>
</tr>
<tr>
<td>25391</td>
<td>lengthening with autograft</td>
</tr>
<tr>
<td>25392</td>
<td>Osteoplasty, radius AND ulna; shortening (excluding 64876)</td>
</tr>
<tr>
<td>25393</td>
<td>lengthening with autograft</td>
</tr>
<tr>
<td>25394</td>
<td>Osteoplasty, carpal bone, shortening</td>
</tr>
<tr>
<td>25400</td>
<td>Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique) with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>25405</td>
<td>Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique) with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>25420</td>
<td>Repair of defect with autograft; radius OR ulna</td>
</tr>
<tr>
<td>25426</td>
<td>radius AND ulna</td>
</tr>
<tr>
<td>25430</td>
<td>Insertion of vascular pedicle into carpal bone (eg, Hori procedure)</td>
</tr>
<tr>
<td>25431</td>
<td>Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone</td>
</tr>
<tr>
<td>25440</td>
<td>Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)</td>
</tr>
<tr>
<td>25441</td>
<td>Arthroplasty with prosthetic replacement; distal radius</td>
</tr>
<tr>
<td>25442</td>
<td>distal ulna</td>
</tr>
<tr>
<td>25443</td>
<td>scaphoid carpal (navicular)</td>
</tr>
<tr>
<td>25444</td>
<td>lunate</td>
</tr>
<tr>
<td>25445</td>
<td>trapezium</td>
</tr>
<tr>
<td>25446</td>
<td>distal radius and partial or entire carpus (&quot;total wrist&quot;)</td>
</tr>
<tr>
<td>25447</td>
<td>Arthroplasty interposition, intercarpal or carpometacarpal joints</td>
</tr>
<tr>
<td>25449</td>
<td>Revision of arthroplasty, including removal of implant, wrist joint</td>
</tr>
<tr>
<td>25450</td>
<td>Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna</td>
</tr>
<tr>
<td>25455</td>
<td>distal radius AND ulna</td>
</tr>
<tr>
<td>25490</td>
<td>Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius</td>
</tr>
<tr>
<td>25491</td>
<td>ulna</td>
</tr>
<tr>
<td>25492</td>
<td>radius AND ulna</td>
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</table>

**FRACTURE AND/OR DISLOCATION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25500</td>
<td>Closed treatment of radial shaft fracture; without manipulation</td>
</tr>
<tr>
<td>25505</td>
<td>with manipulation</td>
</tr>
<tr>
<td>25515</td>
<td>Open treatment of radial shaft fracture, includes internal fixation, when performed</td>
</tr>
<tr>
<td>25520</td>
<td>Closed treatment of radial shaft fracture and closed treatment of dislocation of distal radio-ulnar joint (Galeazzi fracture/dislocation)</td>
</tr>
<tr>
<td>25525</td>
<td>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</td>
</tr>
<tr>
<td>25526</td>
<td>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</td>
</tr>
<tr>
<td>25530</td>
<td>Closed treatment of ulnar shaft fracture; without manipulation</td>
</tr>
<tr>
<td>25535</td>
<td>with manipulation</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>25545</td>
<td>Open treatment of ulnar shaft fracture, includes internal fixation, when performed</td>
</tr>
<tr>
<td>25560</td>
<td>Closed treatment of radial and ulnar shaft fractures; without manipulation</td>
</tr>
<tr>
<td>25565</td>
<td>with manipulation</td>
</tr>
<tr>
<td>25574</td>
<td>Open treatment of radial and ulnar shaft fractures, with internal fixation, when performed; of radius or ulna</td>
</tr>
<tr>
<td>25575</td>
<td>of radius and ulna</td>
</tr>
<tr>
<td>25600</td>
<td>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</td>
</tr>
<tr>
<td>25605</td>
<td>with manipulation</td>
</tr>
<tr>
<td>25606</td>
<td>Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation</td>
</tr>
<tr>
<td>25607</td>
<td>Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation</td>
</tr>
<tr>
<td>25608</td>
<td>with internal fixation of 2 fragments</td>
</tr>
<tr>
<td></td>
<td>(Do not report 25608 in conjunction with 25609)</td>
</tr>
<tr>
<td>25609</td>
<td>Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments</td>
</tr>
<tr>
<td>25622</td>
<td>Closed treatment of carpal scaphoid (navicular) fracture; without manipulation</td>
</tr>
<tr>
<td>25624</td>
<td>with manipulation</td>
</tr>
<tr>
<td>25628</td>
<td>Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed</td>
</tr>
<tr>
<td>25630</td>
<td>Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); without manipulation, each bone</td>
</tr>
<tr>
<td>25635</td>
<td>with manipulation, each bone</td>
</tr>
<tr>
<td>25645</td>
<td>Open treatment of carpal bone fracture (other than carpal scaphoid (navicular)), each bone</td>
</tr>
<tr>
<td>25650</td>
<td>Closed treatment of ulnar styloid fracture</td>
</tr>
<tr>
<td></td>
<td>(Do not report 25650 in conjunction with 25600, 25605, 25607-25609)</td>
</tr>
<tr>
<td>25651</td>
<td>Percutaneous skeletal fixation of ulnar styloid fracture</td>
</tr>
<tr>
<td>25652</td>
<td>Open treatment of ulnar styloid fracture</td>
</tr>
<tr>
<td>25660</td>
<td>Closed treatment of radiocarpal or intercarpal dislocation, one or more bones, with manipulation</td>
</tr>
<tr>
<td>25670</td>
<td>Open treatment of radiocarpal or intercarpal dislocation, one or more bones</td>
</tr>
<tr>
<td>25671</td>
<td>Percutaneous skeletal fixation of distal radioulnar dislocation</td>
</tr>
<tr>
<td>25675</td>
<td>Closed treatment of distal radioulnar dislocation with manipulation</td>
</tr>
<tr>
<td>25676</td>
<td>Open treatment of distal radioulnar dislocation, acute or chronic</td>
</tr>
<tr>
<td>25680</td>
<td>Closed treatment of trans-scaphoperilunar type of fracture dislocation, with manipulation</td>
</tr>
<tr>
<td>25685</td>
<td>Open treatment of trans-scaphoperilunar type of fracture dislocation</td>
</tr>
<tr>
<td>25690</td>
<td>Closed treatment of lunate dislocation, with manipulation</td>
</tr>
<tr>
<td>25695</td>
<td>Open treatment of lunate dislocation</td>
</tr>
</tbody>
</table>

**ARTHRODESIS**

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

AMPUTATION

25900 Amputation, forearm, through radius and ulna;
25905 open, circular (guillotine)
25907 secondary closure or scar revision
25909 re-amputation
25915 Krukenberg procedure
25920 Disarticulation through wrist;
25922 secondary closure or scar revision
25924 re-amputation
25927 Transmetacarpal amputation;
25929 secondary closure or scar revision
25931 re-amputation

OTHER PROCEDURES

25999 Unlisted procedure, forearm or wrist

HAND AND FINGERS

INCISION

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

EXCISION

26100 Arthrotomy with biopsy; carpometacarpal joint, each
26105 metacarpophalangeal joint, each
26110 interphalangeal joint, each
26111  Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater
26113  Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater
26115  Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm
26116  Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm
26117  Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; less than 3 cm
26118       3 cm or greater
26121  Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)
26123  Fasciectomy, partial palmar with release, of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft);
26125       each additional digit
             (List separately in addition to primary procedure)
             (Use 26125 in conjunction with code 26123)
26130  Synovectomy, carpometacarpal joint
26135  Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit
26140  Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint
26145  Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon
26160  Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger
26170  Excision of tendon, palm, flexor, or extensor, single, each tendon
       (Do not report 26170 in conjunction with 26390, 26415)
26180  Excision of tendon, finger, flexor or extensor, each tendon
       (Do not report 26180 in conjunction with 26390, 26415)
26185  Sesamoidectomy, thumb or finger (separate procedure)
26200  Excision or curettage of bone cyst or benign tumor of metacarpal; 26205       with autograft (includes obtaining graft)
26210  Excision or curettage of bone cyst or benign tumor of proximal, middle or distal phalanx; 26215       with autograft (includes obtaining graft)
26230  Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, for osteomyelitis); 26235       proximal or middle phalanx
26236       distal phalanx
26250  Radical resection metacarpal; (eg, tumor)
26260  Radical resection, proximal or middle phalanx of finger (eg, tumor); 26262  Radical resection, distal phalanx of finger (eg, tumor)

INTRODUCTION OR REMOVAL
26320  Removal of implant from finger or hand

**REPAIR, REVISION AND/OR RECONSTRUCTION**

26340  Manipulation, finger joint, under anesthesia, each joint
26341  Manipulation, palmar fascial cord (ie, Dupuytren’s cord), post enzyme injection (eg, collagenase), single cord
26350  Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man’s land); primary or secondary without free graft, each tendon
26352  secondary with free graft (includes obtaining graft), each tendon
26356  Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man’s land); primary, without free graft, each tendon
26357  secondary, without free graft, each tendon
26358  secondary with free graft (includes obtaining graft), each tendon
26370  Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon
26372  secondary with free graft (includes obtaining graft), each tendon
26373  secondary without free graft, each tendon
26390  Excision flexor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod
26392  Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod
26410  Repair, extensor tendon, primary or secondary; without free graft, each tendon
26412  with free graft (includes obtaining graft), each tendon
26415  Excision of extensor tendon, implantation of synthetic rod for delayed tendon graft, hand or finger, each rod
26416  Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod
26418  Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon
26420  with free graft (includes obtaining each tendon graft)
26426  Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); using local tissue(s), including lateral band(s), each finger
26428  with free graft (includes obtaining graft), each finger
26432  Closed treatment of distal extensor tendon insertion, with or without percutaneous pinning (eg, mallet finger)
26433  Repair extensor tendon, distal insertion, primary or secondary; without graft (eg, mallet finger)
26434  with free graft (includes obtaining graft)
26437  Realignment of extensor tendon, hand, each tendon
26440  Tenolysis, flexor tendon; palm OR finger, each tendon
26442  palm AND finger, each tendon
26445  Tenolysis, extensor tendon, hand or finger; each tendon
26449  Tenolysis, complex, extensor tendon, finger, including forearm, each tendon
26450  Tenotomy, flexor, palm, open, each tendon
26455  Tenotomy, flexor, finger, open, each tendon
26460  Tenotomy, extensor, hand or finger, open, each tendon
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>26471</td>
<td>Tenodesis; of proximal interphalangeal joint, each joint</td>
</tr>
<tr>
<td>26474</td>
<td>of distal joint, each joint</td>
</tr>
<tr>
<td>26476</td>
<td>Lengthening of tendon, extensor, hand or finger, each tendon</td>
</tr>
<tr>
<td>26477</td>
<td>Shortening of tendon, extensor, hand or finger, each tendon</td>
</tr>
<tr>
<td>26478</td>
<td>Lengthening of tendon, flexor, hand or finger, each tendon</td>
</tr>
<tr>
<td>26479</td>
<td>Shortening of tendon, flexor, hand or finger, each tendon</td>
</tr>
<tr>
<td>26480</td>
<td>Transfer or transplant of tendon, carpometacarpal area or dorsum of hand, without free graft, each tendon</td>
</tr>
<tr>
<td>26483</td>
<td>with free tendon graft (includes obtaining graft), each tendon</td>
</tr>
<tr>
<td>26485</td>
<td>Transfer or transplant of tendon, palmar; without free tendon graft, each tendon</td>
</tr>
<tr>
<td>26489</td>
<td>with free tendon graft (includes obtaining graft), each tendon</td>
</tr>
<tr>
<td>26490</td>
<td>Opponensplasty; superficialis tendon transfer type, each tendon</td>
</tr>
<tr>
<td>26492</td>
<td>tendon transfer with graft (includes obtaining graft), each tendon</td>
</tr>
<tr>
<td>26494</td>
<td>hypothenar muscle transfer</td>
</tr>
<tr>
<td>26496</td>
<td>other methods</td>
</tr>
<tr>
<td>26497</td>
<td>Transfer of tendon to restore intrinsic function; ring and small finger</td>
</tr>
<tr>
<td>26498</td>
<td>all four fingers</td>
</tr>
<tr>
<td>26499</td>
<td>Correction claw finger, other methods</td>
</tr>
<tr>
<td>26500</td>
<td>Reconstruction of tendon pulley, each tendon; with local tissues (separate procedure)</td>
</tr>
<tr>
<td>26502</td>
<td>with tendon or fascial graft (includes obtaining graft) (separate procedure)</td>
</tr>
<tr>
<td>26508</td>
<td>Release of thenar muscle(s) (eg, thumb contracture)</td>
</tr>
<tr>
<td>26510</td>
<td>Cross intrinsic transfer, each tendon</td>
</tr>
<tr>
<td>26516</td>
<td>Capsulodesis, metacarpophalangeal joint; single digit</td>
</tr>
<tr>
<td>26517</td>
<td>two digits</td>
</tr>
<tr>
<td>26518</td>
<td>three or four digits</td>
</tr>
<tr>
<td>26520</td>
<td>Capsulectomy or capsulotomy; metacarpophalangeal joint, each joint</td>
</tr>
<tr>
<td>26525</td>
<td>interphalangeal joint, each joint</td>
</tr>
<tr>
<td>26530</td>
<td>Arthroplasty, metacarpophalangeal joint; each joint</td>
</tr>
<tr>
<td>26531</td>
<td>with prosthetic implant, each joint</td>
</tr>
<tr>
<td>26535</td>
<td>Arthroplasty interphalangeal joint; each joint</td>
</tr>
<tr>
<td>26536</td>
<td>with prosthetic implant, each joint</td>
</tr>
<tr>
<td>26540</td>
<td>Repair of collateral ligament, metacarpophalangeal or interphalangeal joint</td>
</tr>
<tr>
<td>26541</td>
<td>Reconstruction, collateral ligament, metacarpophalangeal joint, single, with tendon or fascial graft (includes obtaining graft)</td>
</tr>
<tr>
<td>26542</td>
<td>with local tissue (eg, adductor advancement)</td>
</tr>
<tr>
<td>26545</td>
<td>Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint</td>
</tr>
<tr>
<td>26546</td>
<td>Repair non-union, metacarpal or phalanx, (includes obtaining bone graft with or without external or internal fixation)</td>
</tr>
<tr>
<td>26548</td>
<td>Repair and reconstruction, finger, volar plate, interphalangeal joint</td>
</tr>
<tr>
<td>26550</td>
<td>Pollicization of a digit</td>
</tr>
<tr>
<td>26551</td>
<td>Transfer, toe-to-hand with microvascular anastomosis; great toe wrap around with bone graft</td>
</tr>
<tr>
<td>26553</td>
<td>other than great toe, single</td>
</tr>
<tr>
<td>26554</td>
<td>other than great toe, double</td>
</tr>
<tr>
<td>26555</td>
<td>Transfer, finger to another position without microvascular anastomosis</td>
</tr>
<tr>
<td>26556</td>
<td>Transfer, free toe joint, with microvascular anastomosis</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>26560</td>
<td>Repair of syndactyly (web finger), each web space; with skin flaps</td>
</tr>
<tr>
<td>26561</td>
<td>with skin flaps and grafts</td>
</tr>
<tr>
<td>26562</td>
<td>complex (eg, involving bone, nails)</td>
</tr>
<tr>
<td>26565</td>
<td>Osteotomy; metacarpal, each</td>
</tr>
<tr>
<td>26567</td>
<td>phalanx of finger, each</td>
</tr>
<tr>
<td>26568</td>
<td>Osteoplasty, lengthening, metacarpal or phalanx</td>
</tr>
<tr>
<td>26580</td>
<td>Repair cleft hand</td>
</tr>
<tr>
<td>26587</td>
<td>Reconstruction of polydactylyous digit, soft tissue and bone</td>
</tr>
<tr>
<td>26590</td>
<td>Repair macrodactyly, each digit</td>
</tr>
<tr>
<td>26591</td>
<td>Repair, intrinsic muscles of hand, each muscle</td>
</tr>
<tr>
<td>26593</td>
<td>Release, intrinsic muscles of hand, each muscle</td>
</tr>
<tr>
<td>26596</td>
<td>Excision of constricting ring of finger, with multiple Z-plasties</td>
</tr>
</tbody>
</table>

**FRACTURE AND/OR DISLOCATION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>26600</td>
<td>Closed treatment of metacarpal fracture, single; without manipulation, each bone</td>
</tr>
<tr>
<td>26605</td>
<td>with manipulation, each bone</td>
</tr>
<tr>
<td>26607</td>
<td>Closed treatment of metacarpal fracture, with manipulation, with external fixation, each bone</td>
</tr>
<tr>
<td>26608</td>
<td>Percutaneous skeletal fixation of metacarpal fracture, each bone</td>
</tr>
<tr>
<td>26615</td>
<td>Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone</td>
</tr>
<tr>
<td>26641</td>
<td>Closed treatment of carpometacarpal dislocation, thumb, with manipulation</td>
</tr>
<tr>
<td>26645</td>
<td>Closed treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation</td>
</tr>
<tr>
<td>26650</td>
<td>Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation</td>
</tr>
<tr>
<td>26665</td>
<td>Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed</td>
</tr>
<tr>
<td>26670</td>
<td>Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; without anesthesia</td>
</tr>
<tr>
<td>26675</td>
<td>requiring anesthesia</td>
</tr>
<tr>
<td>26676</td>
<td>Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb, with manipulation, each joint</td>
</tr>
<tr>
<td>26685</td>
<td>Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint</td>
</tr>
<tr>
<td>26686</td>
<td>complex, multiple or delayed reduction</td>
</tr>
<tr>
<td>26700</td>
<td>Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia</td>
</tr>
<tr>
<td>26705</td>
<td>requiring anesthesia</td>
</tr>
<tr>
<td>26706</td>
<td>Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation</td>
</tr>
<tr>
<td>26715</td>
<td>Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed</td>
</tr>
<tr>
<td>26720</td>
<td>Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each</td>
</tr>
<tr>
<td>26725</td>
<td>with manipulation, with or without skin or skeletal traction, each</td>
</tr>
</tbody>
</table>
26727  Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each
26735  Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each
26740  Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; without manipulation, each
26742     with manipulation, each
26746  Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each
26750  Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each
26755     with manipulation, each
26756  Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each
26765  Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each
26770  Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia
26775     requiring anesthesia
26776  Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation
26785  Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single

ARTHRODESIS

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

AMPUTATION

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

26989  Unlisted procedure, hands or fingers

PELVIS AND HIP JOINT

Including head and neck of femur.

INCISION

26990  Incision and drainage; pelvis or hip joint area; deep abscess or hematoma
26991  Incision, bone cortex, pelvis and/or hip joint (eg, for osteomyelitis or bone abscess)
27000  Tenotomy, adductor of hip, percutaneous, (separate procedure)
27001  Tenotomy, adductor of hip, open
27003  Tenotomy, adductor, subcutaneous, open, with obturator neurectomy
27005  Tenotomy, hip flexor(s), open (separate procedure)
27006  Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)
27025  Fasciotomy, hip or thigh, any type
(For 27001, 27003, 27025, to report bilateral procedures, use modifier -50)
27027  Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-
minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral
(To report bilateral procedure, use modifier -50)
27030  Arthrotomy, hip, with drainage (eg, infection)
27033  Arthrotomy, hip, including exploration or removal of loose or foreign body
27035  Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral or
obturator nerves
27036  Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release
of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus
femoris, sartorius, iliopsoas)

EXCISION

27040  Biopsy, soft tissues of pelvis and hip area; superficial
27041  Biopsy, soft tissues of pelvis and hip area; deep subfascial or intramuscular
27043  Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater
27045  Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or
greater
27047  Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm
27048  Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5
cm
27049  Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm
27050  Arthrotomy, with biopsy; sacroiliac joint
27052  Arthrotomy, hip joint
27054  Arthrotomy with synovectomy, hip joint
27057  Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral
   (To report bilateral procedure, use modifier -50)
27059  Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater
27060  Excision; ischial bursa
27062   trochanteric bursa or calcification
27065  Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; superficial, includes autograft, when performed
27066   deep (subfascial), includes autograft, when performed
27067   with autograft requiring separate incision
27070  Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial
27071   deep (subfascial or intramuscular)
27075  Radical resection of tumor or infection; wing of ilium, 1 pubic or ischial ramus or symphysis pubis
27076   ilium, including acetabulum, both pubic rami, or ischium and acetabulum
27077   innominate bone, total
27078   ischial tuberosity and greater trochanter of femur
27080  Coccygectomy, primary

INTRODUCTION OR REMOVAL

27086  Removal of foreign body, pelvis or hip; subcutaneous tissue
27087   deep (subfascial or intramuscular)
27090  Removal of hip prosthesis; (separate procedure)
27091   complicated, including total hip prosthesis, methylmethacrylate, with or without insertion of spacer
27093  Injection procedure for hip arthrography; without anesthesia
27095   with anesthesia
   (For 27093, 27095 for radiological supervision and interpretation use 73525. Do not report 77002 in conjunction with 73525)
27096  Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
   (27096 is to be used only with CT or fluoroscopic imaging confirmation of intra-articular needle positioning)
   (Code 27096 is a unilateral procedure. For bilateral procedure, use modifier 50)

REPAIR, REVISION, AND/OR RECONSTRUCTION

27097  Release or recession, hamstring, proximal
27098  Transfer, adductor to ischium
27100  Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft)
27105  Transfer paraspinal muscle to hip (includes fascial or tendon extension graft)
27110  Transfer iliopsoas; to greater trochanter of femur
27111  to femoral neck
27120  Acetabuloplasty; (eg, Whitman, Colonna Haygroves, or cup type)
27122  resection, femoral head (Girdlestone procedure)
27125  Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)
27130  Arthroplasty, acetabular and proximal femoral prosthetic replacement, (total hip arthroplasty),
        with or without autograft or allograft
27132  Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or
        allograft
27134  Revision of total hip arthroplasty; both components, with or without autograft or allograft
27137  acetabular component only, with or without autograft or allograft
27138  femoral component only, with or without allograft
27140  Osteotomy and transfer of greater trochanter of femur (separate procedure)
27146  Osteotomy, iliac, acetabular or innominate bone;
        with open reduction of hip
27151  with femoral osteotomy
27156  with femoral osteotomy and with open reduction of hip
27158  Osteotomy, pelvis, bilateral (eg, congenital malformation)
27161  Osteotomy, femoral neck (separate procedure)
27165  Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or
        cast
27170  Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining
        bone graft)
27175  Treatment of slipped femoral epiphysis; by traction, without reduction
27176  by single or multiple pinning, in situ
27177  Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft
        (includes obtaining graft)
27178  closed manipulation with single or multiple pinning
27179  osteoplasty of femoral neck (Heyman type procedure)
27181  osteotomy and internal fixation
27185  Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur
27187  Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate,
        femoral neck and proximal femur

FRACTURE AND/OR DISLOCATION

27197  Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of
        the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or
        dislocation(s) or the pubic symphysis and/or superior/inferior rami, unilateral or bilateral;
        without manipulation
27198  with manipulation, requiring more than local anesthesia (ie, general anesthesia,
        moderate sedation, spinal/epidural)
27200  Closed treatment of coccygeal fracture
27202  Open treatment of coccygeal fracture
27215  Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, (eg,
        pelvic fracture(s) which do not disrupt the pelvic ring), with internal fixation
27216 Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)

27217 Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes pubic symphysis and/or ipsilateral superior/inferior rami)

27218 Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum) (To report bilateral procedure, report 27215, 27216, 27217, 27218 with modifier -50)

27220 Closed treatment of acetabulum (hip socket) fracture(s); without manipulation

27222 with manipulation, with or without skeletal traction

27226 Open treatment of posterior or anterior acetabular wall fracture, with internal fixation

27227 Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation

27228 Open treatment of acetabular fracture(s) involving anterior and posterior (two) columns, includes T-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture; with internal fixation

27230 Closed treatment of femoral fracture, proximal end, neck; without manipulation

27232 with manipulation, with or without skeletal traction

27235 Percutaneous skeletal fixation of femoral fracture, proximal end, neck

27236 Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement

27238 Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; without manipulation

27240 with manipulation, with or without skin or skeletal traction

27244 Treatment of intertrochanteric, peritrochanteric or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage

27245 with intramedullary implant, with or without interlocking screws and/or cerclage

27246 Closed treatment of greater trochanteric fracture, without manipulation

27248 Open treatment of greater trochanteric fracture, includes internal fixation, when performed

27250 Closed treatment of hip dislocation, traumatic; without anesthesia

27252 requiring anesthesia

27253 Open treatment of hip dislocation, traumatic, without internal fixation

27254 Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation

27256 Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; without anesthesia, without manipulation

27257 with manipulation, requiring anesthesia

27258 Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc);

27259 with femoral shaft shortening

27265 Closed treatment of post hip arthroplasty dislocation; without anesthesia

27266 requiring regional or general anesthesia
27267  Closed treatment of femoral fracture, proximal end, head; without manipulation
27268  Closed treatment of femoral fracture, proximal end, head; with manipulation
27269  Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed

**MANIPULATION**
27275  Manipulation, hip joint, requiring general anesthesia

**ARTHRODESIS**
27279  Arthrodesis, sacroiliac joint, percutaneous or minimally invasive
   (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device
27280  Arthrodesis, open, sacroiliac joint, (including obtaining bone graft), including instrumentation, when performed
   (To report bilateral procedures, use modifier -50)
27282  Arthrodesis, symphysis pubis (including obtaining graft)
27284  Arthrodesis, hip joint (includes obtaining graft);
27286  with subtrochanteric osteotomy

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

**OTHER PROCEDURES**
27299  Unlisted procedure, pelvis or hip joint

**FEMUR (THIGH REGION) AND KNEE JOINT**
Including tibial plateaus.

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

**EXCISION**
27323  Biopsy, soft tissue of thigh or knee area; superficial
27324  deep (subfascial or intramuscular)
27325  Neurectomy, hamstring muscle
27326  Neurectomy, popliteal (gastrocnemius)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27327</td>
<td>Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm</td>
</tr>
<tr>
<td>27328</td>
<td>Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm</td>
</tr>
<tr>
<td>27329</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm</td>
</tr>
<tr>
<td></td>
<td>(see 27364 for 5 cm or greater)</td>
</tr>
<tr>
<td>27330</td>
<td>Arthrotomy, knee; with synovial biopsy only</td>
</tr>
<tr>
<td>27331</td>
<td>including joint exploration, biopsy, or removal of loose or foreign bodies</td>
</tr>
<tr>
<td>27332</td>
<td>Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral</td>
</tr>
<tr>
<td>27333</td>
<td>medial AND lateral</td>
</tr>
<tr>
<td>27334</td>
<td>Arthrotomy, with synovectomy; knee, anterior OR posterior</td>
</tr>
<tr>
<td>27335</td>
<td>anterior AND posterior including popliteal area</td>
</tr>
<tr>
<td>27337</td>
<td>Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater</td>
</tr>
<tr>
<td>27339</td>
<td>Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater</td>
</tr>
<tr>
<td>27340</td>
<td>Excision, prepatellar bursa</td>
</tr>
<tr>
<td>27345</td>
<td>Excision of synovial cyst of popliteal space (eg, Baker's cyst)</td>
</tr>
<tr>
<td>27347</td>
<td>Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee</td>
</tr>
<tr>
<td>27350</td>
<td>Patelllectomy or hemipatelllectomy</td>
</tr>
<tr>
<td>27355</td>
<td>Excision or curettage of bone cyst or benign tumor of femur;</td>
</tr>
<tr>
<td></td>
<td>with allograft</td>
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<tr>
<td>27357</td>
<td>with autograft (includes obtaining graft)</td>
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<tr>
<td>27358</td>
<td>with internal fixation</td>
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<tr>
<td></td>
<td>(List in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 27358 in conjunction with 27355, 27356, or 27357)</td>
</tr>
<tr>
<td>27360</td>
<td>Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia</td>
</tr>
<tr>
<td></td>
<td>and/or fibula (eg, osteomyelitis or bone abscess)</td>
</tr>
<tr>
<td>27364</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater</td>
</tr>
<tr>
<td></td>
<td>(see 27329 for less than 5 cm)</td>
</tr>
<tr>
<td>27365</td>
<td>Radical resection of tumor, bone, femur or knee</td>
</tr>
</tbody>
</table>

**INTRODUCTION OR REMOVAL**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27369</td>
<td>Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography</td>
</tr>
<tr>
<td></td>
<td>(For radiological arthrography radiological supervision and interpretation, use 73580)</td>
</tr>
<tr>
<td>27372</td>
<td>Removal foreign body, deep, thigh region or knee area</td>
</tr>
</tbody>
</table>

**REPAIR, REVISION, AND/OR RECONSTRUCTION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27380</td>
<td>Suture of infrapatellar tendon; primary</td>
</tr>
<tr>
<td>27381</td>
<td>secondary reconstruction, including fascial or tendon graft</td>
</tr>
<tr>
<td>27385</td>
<td>Suture of quadriceps or hamstring muscle rupture; primary</td>
</tr>
<tr>
<td>27386</td>
<td>secondary reconstruction, including fascial or tendon graft</td>
</tr>
<tr>
<td>27390</td>
<td>Tenotomy, open, hamstring, knee to hip; single tendon</td>
</tr>
<tr>
<td>27391</td>
<td>multiple tendons, one leg</td>
</tr>
<tr>
<td>27392</td>
<td>multiple tendons, bilateral</td>
</tr>
</tbody>
</table>
27393  Lengthening of hamstring tendon; single tendon
27394   multiple tendons, one leg
27395   multiple tendons, bilateral
27396  Transplant or transfer (with muscle redirection or rerouting), thigh (eg, extensor to flexor); single tendon
27397   multiple tendons
27400  Transfer tendon or muscle, hamstrings to femur (eg, Eggers type procedure)
27403  Arthrotomy with open meniscus repair, knee
27405  Repair, primary, torn ligament and/or capsule, knee; collateral
cruciate
27407  collateral and cruciate ligaments
27415  Osteochondral allograft, knee, open
27416  Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])
(Do not report 27416 in conjunction with 27415, 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)
27418  Anterior tibial tubercleplasty (eg, Maquet type procedure)
27420  Reconstruction of dislocating patella; (eg, Hauser type procedure)
27422   with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)
27424   with patellectomy
27425  Lateral retinacular release open
27427  Ligamentous reconstruction (augmentation), knee; extra-articular
27428   intra-articular (open)
27429   intra-articular (open) and extra-articular
27430  Quadricepsplasty (eg, Bennett or Thompson type)
27435  Capsulotomy, posterior release, knee
27437  Arthroplasty, patella; without prosthesis
27438   with prosthesis
27440  Arthroplasty, knee, tibial plateau;
27441   with debridement and partial synovectomy
27442  Arthroplasty, femoral condyles or tibial plateau(s), knee;
27443   with debridement and partial synovectomy
27445  Arthroplasty, knee, hinge prosthesis (eg, Walldius type)
27446  Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
27447   medial AND lateral compartments with or without patella resurfacing (total knee replacement)
27448  Osteotomy, femur, shaft or supracondylar; without fixation
27450   with fixation
27454  Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft, (eg, Sofield type procedure)
27455  Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)); before epiphyseal closure
27457   after epiphyseal closure
(To report 27448-27450, 27455-27457 as bilateral procedures, use modifier -50)

27465 Osteoplasty, femur; shortening (excluding 64876)
27466 lengthening
27468 combined, lengthening and shortening with femoral segment transfer
27470 Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)
27472 with iliac or other autogenous bone graft (includes obtaining graft)
27475 Arrest, epiphyseal, any method (eg, epiphysiodesis); distal femur
27477 tibia and fibula, proximal
27479 combined distal femur, proximal tibia and fibula
27485 Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, for genu varus or valgus)
27486 Revision of total knee arthroplasty, with or without allograft; one component
27487 femoral and entire tibial component
27488 Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee
27495 Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femur
27496 Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);
27497 with debridement of nonviable muscle and/or nerve
27498 Decompression fasciotomy, thigh and/or knee, multiple compartments;
27499 with debridement of nonviable muscle and/or nerve

FRACTURE AND/OR DISLOCATION

27500 Closed treatment of femoral shaft fracture, without manipulation
27501 Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation
27502 Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction
27503 Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension; with manipulation, with or without skin or skeletal traction
27506 Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws
27507 Open treatment of femoral shaft fracture with plate/screws, with or without cerclage
27508 Closed treatment of femoral fracture, distal end, medial or lateral condyle, without manipulation
27509 Percutaneous skeletal fixation of femoral fracture, distal end, medial or lateral condyle, or supracondylar or transcondylar, with or without intercondylar extension, or distal femoral epiphyseal separation
27510 Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation
27511 Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed
27513 Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed
27514  Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed
27516  Closed treatment of distal femoral epiphyseal separation; without manipulation
27517       with manipulation, with or without skin or skeletal traction
27519  Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed
27520  Closed treatment of patellar fracture, without manipulation
27524  Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair
27530  Closed treatment of tibial fracture, proximal (plateau); without manipulation
27532       with or without manipulation, with skeletal traction
27535  Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed
27536       bicondylar, with or without internal fixation
27538  Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation
27540  Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed
27550  Closed treatment of knee dislocation; without anesthesia
27552       requiring anesthesia
27556  Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction
27557       with primary ligamentous repair
27558       with primary ligamentous repair, with augmentation/reconstruction
27560  Closed treatment of patellar dislocation; without anesthesia
27562       requiring anesthesia
27566  Open treatment of patellar dislocation, with or without partial or total patellectomy

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

**ARTHRODESIS**
27580  Arthrodesis, knee, any technique

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

27599  Unlisted procedure, femur or knee

LEG (TIBIA AND FIBULA) AND ANKLE JOINT

INCISION

27600  Decompression fasciotomy, leg; anterior and/or lateral compartments only
27601   posterior compartment(s) only
27602   anterior and/or lateral, and posterior compartment(s)
27603  Incision and drainage; deep abscess or hematoma
27604   infected bursa
27605  Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia
27606   general anesthesia
27607  Incision, (eg, osteomyelitis or bone abscess) leg or ankle
27610  Arthrotomy, ankle, including exploration, drainage or removal of foreign body
27612  Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening

EXCISION

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

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

REPAIR, REVISION, AND/OR RECONSTRUCTION

27650  Repair, primary, open or percutaneous ruptured Achilles tendon;  
27652    with graft (includes obtaining graft)  
27654  Repair, secondary, ruptured Achilles tendon, with or without graft  
27656  Repair, fascial defect of leg  
27658  Repair or suture of flexor tendon, leg; primary, without graft, each tendon  
27659    secondary with or without graft, each tendon  
27664  Repair, extensor tendon, leg; primary, without graft, each tendon  
27665    secondary with or without graft, each tendon  
27675  Repair dislocating peroneal tendons; without fibular osteotomy  
27676    with fibular osteotomy  
27680  Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon  
27681    multiple tendons (through same incision(s))  
27685  Lengthening or shortening of tendon; leg or ankle; single tendon (separate procedure)  
27686    multiple tendons (through same incision), each  
27687  Gastrocnemius recession (eg, Strayer procedure)  
27690  Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)  
27691    deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)  
27692    each additional tendon  
27695    (List separately in addition to primary procedure)  
27696    (Use 27692 in conjunction with 27690, 27691)  
27699  Repair, primary, disrupted ligament, ankle; collateral  
27700  both collateral ligaments  
27702  Repair, secondary disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)  
27700  Arthroplasty, ankle;  
27702    with implant (total ankle)  
27703  revision, total ankle  
27704  Removal of ankle implant  
27705  Osteotomy; tibia  
27707    fibula  
27709    tibia and fibula  
27712    multiple, with realignment on intramedullary rod (eg, Sofield type procedure)  
27715  Osteoplasty, tibia and fibula, lengthening or shortening  
27720  Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)  
27722    with sliding graft  
27724    with iliac or other autograft (includes obtaining graft)  
27725    by synostosis, with fibula, any method
27726 repair of fibula nonunion and/or malunion with internal fixation
(Do not report 27726 in conjunction with 27707)
27727 Repair of congenital pseudarthrosis, tibia
27730 Arrest, epiphyseal (epiphysiodesis), open; distal tibia
27732 distal fibula
27734 distal tibia and fibula
27740 Arrest epiphyseal, (epiphysiodesis), any method; combined, proximal and distal tibia and fibula;
27742 and distal femur
27745 Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia

FRACTURE AND/OR DISLOCATION

27750 Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation
27752 with manipulation, with or without skeletal traction
27756 Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture) (eg, pins or screws)
27758 Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with or without cerclage
27759 Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage
27760 Closed treatment of medial malleolus fracture; without manipulation
27762 with manipulation, with or without skin or skeletal traction
27766 Open treatment of medial malleolus fracture, includes internal fixation, when performed
27767 Closed treatment of posterior malleolus fracture; without manipulation
27768 with manipulation
27769 Open treatment of posterior malleolus fracture, includes internal fixation, when performed
(Do not report 27767-27769 in conjunction with 27808-27823)
27780 Closed treatment of proximal fibula or shaft fracture; without manipulation
27781 with manipulation
27784 Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed
27786 Closed treatment of distal fibular fracture (lateral malleolus); without manipulation
27788 with manipulation
27792 Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed
27808 Closed treatment of bimalleolar ankle fracture, (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); without manipulation
27810 with manipulation
27814 Open treatment of bimalleolar ankle fracture, (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed
27816 Closed treatment of trimalleolar ankle fracture; without manipulation
27818 with manipulation
27822 Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip
27823  with fixation of posterior lip
27824  Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation
27825  with skeletal traction and/or requiring manipulation
27826  Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation; when performed; of fibula only
27827  of tibia only
27828  of both tibia and fibula
27829  Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed
27830  Closed treatment of proximal tibiofibular joint dislocation; without anesthesia
27831  requiring anesthesia
27832  Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula
27840  Closed treatment of ankle dislocation; without anesthesia
27842  requiring anesthesia, with or without percutaneous skeletal fixation
27846  Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation
27848  with repair or internal or external fixation

MANIPULATION

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

ARTHRODESIS

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

AMPUTATION

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

OTHER PROCEDURES

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

FOOT AND TOES

INCISION

28001 Incision and drainage bursa, foot
28002 Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space
28003 multiple areas
28005 Incision, bone cortex (eg, for osteomyelitis or bone abscess), foot
28008 Fasciotomy, foot and/or toe
(See also 28060, 28062, 28250)
28010 Tenotomy, percutaneous, toe; single tendon
28011 multiple tendons
28020 Arthrotenomy, with exploration, drainage or removal of loose or foreign body; intertarsal or tarsometatarsal joint
28022 metatarsophalangeal joint
28024 interphalangeal joint
28035 Release, tarsal tunnel (posterior tibial nerve decompression)

EXCISION

28039 Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater
28041 Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater
28043 Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm
28045 Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm
28046 Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm
28047 3 cm or greater
28050 Arthrotenomy with biopsy; intertarsal or tarsometatarsal joint
28052 metatarsophalangeal joint
28054 interphalangeal joint
28055 Neurectomy, intrinsic musculature of foot
28060 Fasciectomy, plantar fascia; partial (separate procedure)
28062 radical (separate procedure)
28070 Synovectomy; intertarsal or tarsometatarsal joint, each
28072 metatarsophalangeal joint, each
28080 Excision of interdigital (Morton) neuroma, single, each
28086 Synovectomy, tendon sheath, foot; flexor
28088 extensor
28090 Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (cyst or ganglion); foot
28092 toe(s), each
28100 Excision or curettage of bone cyst or benign tumor, talus or calcaneus;
28102 with iliac or other autograft (includes obtaining graft)
28103    with allograft  
28104   Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus;  
28106    with iliac or other autograft (includes obtaining graft)  
28107    with allograft  
28108   Excision or curettage of bone cyst or benign tumor, phalanges of foot  
28110 Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)  
28111 Ostectomy, complete excision; first metatarsal head  
28112    other metatarsal head (second, third or fourth)  
28113    fifth metatarsal head  
28114   all metatarsal heads, with partial proximal phalangeal excision, 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 (craeration, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus  
28122    tarsal or metatarsal bone except talus or calcaneus  
28124 phalanx of toe  
28126 Resection, partial or complete, phalangeal base, each toe  
28130 Talectomy (astragalectomy)  
28140 Metatarsectomy  
28150 Phalangectomy, toe, each toe  
28153 Resection, condyle(s), distal end of phalanx, each toe  
28160 Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each  
28171 Radical resection of tumor; tarsal (except talus or calcaneus)  
28173 metatarsal  
28175 phalanx of toe  

**INTRODUCTION OR REMOVAL**  
28190 Remove foreign body, foot; subcutaneous  
28192 deep  
28193 complicated  

**REPAIR, REVISION, AND/OR RECONSTRUCTION**  
28200 Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon  
28202 secondary with free graft, each tendon (includes obtaining graft)  
28208 Repair, tendon, extensor, foot; primary or secondary, each tendon  
28210 secondary with free graft, each tendon (includes obtaining graft)  
28220 Tenolysis, flexor, foot; single tendon  
28222 multiple tendons  
28225 Tenolysis, extensor, foot; single tendon  
28226 multiple tendons  
28230 Tenotomy, open, tendon flexor; foot, single or multiple tendon(s) (separate procedure)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>28232</td>
<td>toe, single tendon (separate procedure)</td>
</tr>
<tr>
<td>28234</td>
<td>Tenotomy, open, extensor, foot or toe, each tendon</td>
</tr>
<tr>
<td>28238</td>
<td>Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)</td>
</tr>
<tr>
<td>28240</td>
<td>Tenotomy lengthening, or release, abductor hallucis muscle</td>
</tr>
<tr>
<td>28250</td>
<td>Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure)</td>
</tr>
<tr>
<td>28260</td>
<td>Capsulotomy, midfoot; medial release only (separate procedure)</td>
</tr>
<tr>
<td>28261</td>
<td>with tendon lengthening</td>
</tr>
<tr>
<td>28262</td>
<td>extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)</td>
</tr>
<tr>
<td>28264</td>
<td>Capsulotomy, midtarsal (eg, Heyman type procedure)</td>
</tr>
<tr>
<td>28270</td>
<td>Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)</td>
</tr>
<tr>
<td>28272</td>
<td>interphalangeal joint, each joint (separate procedure)</td>
</tr>
<tr>
<td>28280</td>
<td>Syndactylization, toes (eg, webbing or Kelikian type procedure)</td>
</tr>
<tr>
<td>28285</td>
<td>Correction, hammertoe; (eg, interphalangeal fusion, partial or total phalangectomy)</td>
</tr>
<tr>
<td>28286</td>
<td>Correction, cock-up fifth toe, with plastic skin closure (Ruiz-Mora type procedure)</td>
</tr>
<tr>
<td>28288</td>
<td>Osteotomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head</td>
</tr>
<tr>
<td>28289</td>
<td>Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant</td>
</tr>
<tr>
<td>28291</td>
<td>with implant</td>
</tr>
<tr>
<td>28292</td>
<td>Correction, hallux valgus (bunionectomy), with sesamoidectomy when performed; with resection of proximal phalanx base, when performed, any method</td>
</tr>
<tr>
<td>28296</td>
<td>with distal metatarsal osteotomy, any method</td>
</tr>
<tr>
<td>28297</td>
<td>with first metatarsal and medical cuneiform joint arthrodesis, any method</td>
</tr>
<tr>
<td>28298</td>
<td>with proximal phalanx osteotomy, any method</td>
</tr>
<tr>
<td>28300</td>
<td>Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation</td>
</tr>
<tr>
<td>28302</td>
<td>talus</td>
</tr>
<tr>
<td>28304</td>
<td>Osteotomy, tarsal bones, other than calcaneus or talus;</td>
</tr>
<tr>
<td>28305</td>
<td>with autograft (includes obtaining graft) (eg, Fowler type)</td>
</tr>
<tr>
<td>28306</td>
<td>Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal</td>
</tr>
<tr>
<td>28310</td>
<td>Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)</td>
</tr>
<tr>
<td>28312</td>
<td>other phalanges, any toe</td>
</tr>
<tr>
<td>28313</td>
<td>Reconstruction, angular deformity of toe, soft tissue procedures only (overlapping second toe, fifth toe, curly toes)</td>
</tr>
<tr>
<td>28315</td>
<td>Sesamoidectomy, first toe (separate procedure)</td>
</tr>
<tr>
<td>28320</td>
<td>Repair of nonunion or malunion; tarsal bones</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>28322</td>
<td>Metatarsal, with or without bone graft (includes obtaining graft)</td>
</tr>
<tr>
<td>28340</td>
<td>Reconstruction, toe, macrodactyly; soft tissue resection</td>
</tr>
<tr>
<td>28341</td>
<td>Requiring bone resection</td>
</tr>
<tr>
<td>28344</td>
<td>Reconstruction, toe(s); polydactyly</td>
</tr>
<tr>
<td>28345</td>
<td>Syndactyly, with or without skin graft(s), each web</td>
</tr>
<tr>
<td>28360</td>
<td>Reconstruction, cleft foot</td>
</tr>
</tbody>
</table>

**FRACTURE AND/OR DISLOCATION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>28400</td>
<td>Closed treatment of calcaneal fracture; without manipulation</td>
</tr>
<tr>
<td>28405</td>
<td>With manipulation</td>
</tr>
<tr>
<td>28406</td>
<td>Percutaneous skeletal fixation of calcaneal fracture, with manipulation</td>
</tr>
<tr>
<td>28415</td>
<td>Open treatment of calcaneal fracture, includes internal fixation, when performed;</td>
</tr>
<tr>
<td>28420</td>
<td>With primary iliac or other autogenous bone graft (includes obtaining graft)</td>
</tr>
<tr>
<td>28430</td>
<td>Closed treatment of talus fracture; without manipulation</td>
</tr>
<tr>
<td>28435</td>
<td>With manipulation</td>
</tr>
<tr>
<td>28436</td>
<td>Percutaneous skeletal fixation of talus fracture, with manipulation</td>
</tr>
<tr>
<td>28445</td>
<td>Open treatment of talus fracture, includes internal fixation, when performed</td>
</tr>
<tr>
<td>28446</td>
<td>Open osteochondral autograft, talus (includes obtaining graft[s])</td>
</tr>
<tr>
<td></td>
<td>(Do not report 28446 in conjunction with 27705, 27707)</td>
</tr>
<tr>
<td>28450</td>
<td>Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each</td>
</tr>
<tr>
<td>28455</td>
<td>With manipulation, each</td>
</tr>
<tr>
<td>28456</td>
<td>Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each</td>
</tr>
<tr>
<td>28465</td>
<td>Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed</td>
</tr>
<tr>
<td>28470</td>
<td>Closed treatment of metatarsal fracture; without manipulation, each</td>
</tr>
<tr>
<td>28475</td>
<td>With manipulation, each</td>
</tr>
<tr>
<td>28476</td>
<td>Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each</td>
</tr>
<tr>
<td>28485</td>
<td>Open treatment of metatarsal fracture, includes internal fixation, when performed, each</td>
</tr>
<tr>
<td>28490</td>
<td>Closed treatment of fracture great toe, phalanx or phalanges; without manipulation</td>
</tr>
<tr>
<td>28495</td>
<td>With manipulation</td>
</tr>
<tr>
<td>28496</td>
<td>Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges, with manipulation</td>
</tr>
<tr>
<td>28505</td>
<td>Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed</td>
</tr>
<tr>
<td>28510</td>
<td>Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each</td>
</tr>
<tr>
<td>28515</td>
<td>With manipulation, each</td>
</tr>
<tr>
<td>28525</td>
<td>Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each</td>
</tr>
<tr>
<td>28530</td>
<td>Closed treatment of sesamoid fracture</td>
</tr>
<tr>
<td>28531</td>
<td>Open treatment of sesamoid fracture, with or without internal fixation</td>
</tr>
<tr>
<td>28540</td>
<td>Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia</td>
</tr>
<tr>
<td>28545</td>
<td>Requiring anesthesia</td>
</tr>
<tr>
<td>28546</td>
<td>Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation</td>
</tr>
</tbody>
</table>
28555 Open treatment of tarsal bone dislocation, includes internal fixation, when performed
28570 Closed treatment of talotarsal joint dislocation; without anesthesia
28575 requiring anesthesia
28576 Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation
28585 Open treatment of talotarsal joint dislocation, includes internal fixation, when performed
28600 Closed treatment of tarsometatarsal joint dislocation; without anesthesia
28605 requiring anesthesia
28606 Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation
28615 Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed
28630 Closed treatment of metatarsophalangeal joint dislocation; without anesthesia
28635 requiring anesthesia
28636 Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation
28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed
28660 Closed treatment of interphalangeal joint dislocation; without anesthesia
28665 requiring anesthesia
28666 Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation
28675 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed

ARTHRODESIS

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

AMPUTATION

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

OTHER PROCEDURES

28899 Unlisted procedure, foot or toes
APPLICATION OF CASTS AND STRAPPING

(Separate Procedure Only)

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

BODY AND UPPER EXTREMITY

CASTS

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

SPLINTS

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

LOWER EXTREMITY

CASTS

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

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

STRAPPING-ANY AGE

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

REMOVAL OR REPAIR

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

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

OTHER PROCEDURES

29799 Unlisted procedure, casting or strapping

ENDOSCOPY/ARTHROSCOPY

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

29800 Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)
29804 Arthroscopy, temporomandibular joint, surgical
29805 Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
29806 Arthroscopy, shoulder, surgical; capsulorrhaphy
29807 repair of slap lesion
29819 Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
29820 synovectomy, partial
29821 synovectomy, complete
29822 debridement, limited
29823 debridement, extensive
29824 distal claviculectomy including distal articular surface (Mumford procedure)
29825 with lysis and resection of adhesions with or without manipulation
29826 decompression of subacromial space with partial acroimioplasty, with coracoacromial ligament (ie, arch) release, when performed
   (List separately in addition to primary procedure)
Use 29826 in conjunction with 29806-29825, 29827, 29828

29827  with rotator cuff
29828  Arthroscopy, shoulder, surgical; biceps tenodesis
(Do not report 29828 in conjunction with 29805, 29820, 29822)
29830  Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
29834  Arthroscopy, elbow, surgical; with removal of loose body or foreign body
29835  synovectomy, partial
29836  synovectomy, complete
29837  debridement, limited
29838  debridement, extensive
29840  Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)
29843  Arthroscopy, wrist, surgical; for infection, lavage and drainage
29844  synovectomy, partial
29845  synovectomy, complete
29846  excision and/or repair of triangular fibrocartilage and/or joint debridement
29847  internal fixation for fracture or instability
29850  Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)
29851  with internal or external fixation (includes arthroscopy)
29855  Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed (includes arthroscopy)
29856  bicondylar, includes internal fixation, when performed (includes arthroscopy)
29860  Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)
29861  Arthroscopy, hip, surgical; with removal of loose body or foreign body
29862  with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
29863  with synovectomy
29866  Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])
(Do not report 29866 in conjunction with 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)
29867  osteochondral allograft (eg, mosaicplasty)
(Do not report 29867 in conjunction with 27570, 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)
(Do not report 29867 in conjunction with 27415)
29868  meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
(Do not report 29868 in conjunction with 29870, 29871, 29875, 29880, 29883, 29884 when performed at the same session or 29874, 29877, 29881, 29882 when performed in the same compartment)
29870  Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29871  Arthroscopy, knee, surgical; for infection, lavage and drainage
29873  with lateral release
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>29874</td>
<td>for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)</td>
</tr>
<tr>
<td>29875</td>
<td>synovectomy, limited (eg, plica or shelf resection) (separate procedure)</td>
</tr>
<tr>
<td>29876</td>
<td>synovectomy, major, two or more compartments (eg, medial or lateral)</td>
</tr>
<tr>
<td>29877</td>
<td>debridement/shaving of articular cartilage (chondroplasty)</td>
</tr>
<tr>
<td>29879</td>
<td>abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture</td>
</tr>
<tr>
<td>29880</td>
<td>with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed</td>
</tr>
<tr>
<td>29881</td>
<td>with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed</td>
</tr>
<tr>
<td>29882</td>
<td>with meniscus repair (medial or lateral)</td>
</tr>
<tr>
<td>29883</td>
<td>with meniscus repair (medial and lateral)</td>
</tr>
<tr>
<td>29884</td>
<td>with lysis of adhesions with or without manipulation (separate procedure)</td>
</tr>
<tr>
<td>29885</td>
<td>drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)</td>
</tr>
<tr>
<td>29886</td>
<td>drilling for intact osteochondritis dissecans lesion</td>
</tr>
<tr>
<td>29887</td>
<td>drilling for intact osteochondritis dissecans lesion with internal fixation</td>
</tr>
<tr>
<td>29888</td>
<td>Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction</td>
</tr>
<tr>
<td>29889</td>
<td>Arthroscopically aided posterior cruciate ligament repair/ augmentation or reconstruction (Procedures 29888 and 29889 should not be used with reconstruction procedures 27427-27429)</td>
</tr>
<tr>
<td>29891</td>
<td>Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and/or tibia, including drilling of the defect</td>
</tr>
<tr>
<td>29892</td>
<td>Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)</td>
</tr>
<tr>
<td>29893</td>
<td>Endoscopic plantar fasciotomy</td>
</tr>
<tr>
<td>29894</td>
<td>Arthroscopy ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body</td>
</tr>
<tr>
<td>29895</td>
<td>synovectomy, partial</td>
</tr>
<tr>
<td>29897</td>
<td>debridement, limited</td>
</tr>
<tr>
<td>29898</td>
<td>debridement, extensive</td>
</tr>
<tr>
<td>29899</td>
<td>with ankle arthrodesis</td>
</tr>
<tr>
<td>29900</td>
<td>Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy (Do not report 29900 with 29901, 29902)</td>
</tr>
<tr>
<td>29901</td>
<td>Arthroscopy, metacarpophalangeal joint, surgical; with debridement</td>
</tr>
<tr>
<td>29902</td>
<td>with reduction of displaced ulnar collateral ligament (eg, Stenar Lesion)</td>
</tr>
<tr>
<td>29904</td>
<td>Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body</td>
</tr>
<tr>
<td>29905</td>
<td>Arthroscopy, subtalar joint, surgical; with synovectomy</td>
</tr>
<tr>
<td>29906</td>
<td>Arthroscopy, subtalar joint, surgical; with debridement</td>
</tr>
<tr>
<td>29907</td>
<td>Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis</td>
</tr>
<tr>
<td>29914</td>
<td>Arthroscopy, hip, surgical; with removal of loose body or foreign body with femoroplasty (ie., treatment of cam lesion)</td>
</tr>
</tbody>
</table>
29915 with acetabuloplasty (ie, treatment of pincer lesion)
(Do not report 29914, 29915 in conjunction with 29862, 29863)
29916 with labral repair
(Do not report 29916 for labral repair secondary to acetabuloplasty or in conjunction with 29862, 29863)
29999 Unlisted procedure, arthroscopy

**RESPIRATORY SYSTEM**

**NOSE**

**INCISION**

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

**EXCISION**

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

**INTRODUCTION**

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

**REMOVAL OF FOREIGN BODY**

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

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

DESTRUCTION

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

OTHER PROCEDURES

30901 Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
(To report bilateral procedure, use modifier -50)
30903 Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method
(To report bilateral procedure, use modifier -50)
30905 Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial
30906 subsequent
30915 Ligation arteries; ethmoidal
30920 internal maxillary artery, transantral
30930 Fracture nasal inferior turbinate(s), therapeutic
(Do not report 30801, 30802, 30930 in conjunction with 30130 or 30140)
30999 Unlisted procedure, nose

ACCESSORY SINUSES

INCISION

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

EXCISION

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

ENDOSCOPY

A surgical sinus endoscopy includes a sinusotomy (when appropriate) and diagnostic endoscopy. Codes 31233-31297 are used to report unilateral procedures unless otherwise specified. The codes 31231-31235 for diagnostic evaluation refer to employing a nasal/sinus endoscope to inspect the interior of the nasal cavity and the middle and superior meatus, the turbinates, and the sphenethmoid recess. Any time a diagnostic evaluation is performed all these areas would be inspected and a separate code is not reported for each area.

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

OTHER PROCEDURES
31299 Unlisted procedure, accessory sinuses

LARYNX

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

INTRODUCTION

31500  Intubation, endotracheal, emergency procedure

ENDOSCOPY

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

31505  Laryngoscopy, indirect; diagnostic (separate procedure)
31510  with biopsy
31511  with removal of foreign body
31512  with removal of lesion
31513  with vocal cord injection
31515  Laryngoscopy, direct, with or without tracheoscopy; for aspiration
31520  diagnostic, newborn
(Do not report 31520 with modifier –63)
31525  diagnostic, except newborn
31526  diagnostic, with operating microscope or telescope
31527  with insertion of obturator
31528  with dilation, initial
31529  with dilation, subsequent
31530  Laryngoscopy, direct, operative, with foreign body removal;
31531  with operating microscope or telescope
31535  Laryngoscopy, direct, operative, with biopsy;
31536  with operating microscope or telescope
31540  Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis;
31541  with operating microscope or telescope
31545  Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)
31546  reconstruction with graft(s) (includes obtaining autograft)
(Do not report 31546 in addition to 20926 for graft harvest)
(Do not report 31545 or 31546 in conjunction with 31540, 31541)
31560  Laryngoscopy, direct, operative, with arytenoidectomy;
31561  with operating microscope or telescope
31570  Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;
31571  with operating microscope or telescope
31575  Laryngoscopy, flexible; diagnostic
31576  with biopsy(ies)
31577  with removal of foreign body(s)
Physician - Procedure Codes, Section 5 - Surgery

31578 with removal of lesion(s), non-laser
31572 with ablation or destruction of lesion(s) with laser, unilateral
31573 with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral
31574 with injection(s) for augmentation (eg, percutaneous, transoral), unilateral
31579 Laryngoscopy, flexible or rigid telescopic, with stroboscopy

REPAIR

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

DESTRUCTION

OTHER PROCEDURES

31599 Unlisted procedure, larynx

TRACHEA AND BRONCHI

INCISION

31600 Tracheostomy, planned (separate procedure); under two years
31603 Tracheostomy, emergency procedure; transtracheal
31605 cricothyroid membrane
31610 Tracheostomy, fenestration procedure with skin flaps
31611 Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)
31612 Tracheal puncture, percutaneous with transtracheal aspiration and/or injection
31613 Tracheostoma revision; simple, without flap rotation
31614 complex, with flap rotation

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

31615  Tracheobronchoscopy through established tracheostomy incision
31622  Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)
31623  with brushing or protected brushings
31624  with bronchial alveolar lavage
31625  with bronchial or endobronchial biopsy(s), single or multiple sites
31626  with placement of fiducial markers, single or multiple
   (Report supply of device separately)
31628  with transbronchial lung biopsy(s), single lobe
   (31628 should be reported only once regardless of how many transbronchial lung biopsies are performed in a lobe)
31629  with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)
   (31629 should be reported only once for upper airway biopsies regardless of how many transbronchial needle aspiration biopsies are performed in the upper airway or in a lobe)
31630  with tracheal/bronchial dilation or closed reduction of fracture
31631  with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)
31632  with transbronchial lung biopsy(s), each additional lobe
   (List separately in addition to primary procedure)
   (Use 31632 in conjunction with 31628)
   (31632 should be reported only once regardless of how many transbronchial lung biopsies are performed in a lobe)
31633  with transbronchial needle aspiration biopsy(s), each additional lobe
   (List separately in addition to primary procedure)
   (Use 31633 in conjunction with 31629)
   (31633 should be reported only once regardless of how many transbronchial needle aspiration biopsies are performed in the trachea or the additional lobe)
31634  with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed
31635  with removal of foreign body
31636  with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus
31637  each additional major bronchus stented
   (List separately in addition to primary procedure)
   (Use 31637 in conjunction with 31636)
31638  with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)
31640  with excision of tumor
31641  with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)
31643  with placement of catheter(s) for intracavitary radioelement application
31645  with therapeutic aspiration of tracheobronchial tree, initial
31646  with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay
31647  with balloon occlusion, when performed, assessment of air leak, airway sizing, and
insertion of bronchial valve(s), initial lobe
31651  with balloon occlusion, when performed, assessment of air leak, airway sizing, and
insertion of bronchial valve(s), each additional lobe
   (List separately in addition to primary procedure[s])
31648  with removal of bronchial valve(s), initial lobe
31649  with removal of bronchial valve(s), each additional lobe
   (List separately in addition to primary procedure)
31652  with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial
sampling (eg, aspiration[s]/biopsy[ies]), one or two
mediastinal and/or hilar lymph node stations or structures
31653  with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial
sampling (eg, aspiration[s]/biopsy[ies]), 3 or more
mediastinal and/or hilar lymph node stations or structures
31654  with transendoscopic endobronchial ultrasound (EBUS) during
bronchoscopic diagnostic or therapeutic intervention(s) for
peripheral lesion(s)
   (List separately in addition to code for primary procedure[s])
   (Use 31654 in conjunction with 31622, 31623, 31624, 31625, 31626, 31628,31629,
31640, 31643, 31645, 31646)
   (For EBUS to access mediastinal or hilar lymph node station(s) of adjacent structure(s),
see 31652, 31653)
   (Report 31652, 31653, 31654 only once per session)

INTRODUCTION

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

EXCISION, REPAIR

31750  Tracheoplasty; cervical
31755      tracheopharyngeal fistulization, each stage
31760      intrathoracic
31766  Carinal reconstruction
31770  Bronchoplasty; graft repair
31775      excision stenosis and anastomosis
31780  Excision tracheal stenosis and anastomosis; cervical
31781      cervicothoracic
31785  Excision of tracheal tumor or carcinoma; cervical
31786      thoracic
31800  Suture of tracheal wound or injury; cervical
31805 intrathoracic
31820 Surgical closure tracheostomy or fistula; without plastic repair
31825 with plastic repair
31830 Revision of tracheostomy scar

OTHER PROCEDURES
31899 Unlisted procedure, trachea, bronchi

LUNGS AND PLEURA

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

EXCISION
32310 Pleurectomy; parietal (separate procedure)
32320 Decortication and parietal pleurectomy
32400 Biopsy, pleura; percutaneous needle
32405 Biopsy, lung or mediastinum, percutaneous needle

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

INTRODUCTION AND REMOVAL
32550  Insertion of indwelling tunneled pleural catheter with cuff
       (Do not report 32550 in conjunction with 32554, 32555)
32551  Tube thoracostomy, includes connection to drainage system (eg, water seal), when
       performed, open (separate procedure)
       (Do not report 32551 in conjunction with 19260, 19271, 19272, 32100, 32504)
32552  Removal of indwelling tunneled pleural catheter with cuff
32553  Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers,
dosimeter), percutaneous, intra-thoracic, single or multiple
       (Report supply of device separately)
32554  Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance
32555   with imaging guidance
32556  Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance
32557   with imaging guidance

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

ENDOSCOPY
Surgical thoracoscopy always includes diagnostic thoracoscopy.

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

32601  Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without biopsy
32604   pericardial sac, with biopsy
32606   mediastinal space, with biopsy
32607  Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
   (Do not report 32607 in conjunction with 32440, 32442, 32445, 32488, 32671)
32608   with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
   (Do not report 32608 in conjunction with 32440, 32442, 32445, 32488, 32671)
32609   with biopsy(ies) of pleura
32650  Thoracoscopy, surgical; with pleurodesis, (eg, mechanical or chemical)
32651   with partial pulmonary decortication
32652   with total pulmonary decortication, including intrapleural pneumonolysis
32653   with removal of intrapleural foreign body or fibrin deposit
32654   with control of traumatic hemorrhage
32655   with resection-plication of bullae, includes any pleural procedure when performed
32656   with parietal pleurectomy
32658   with removal of clot or foreign body from pericardial sac
32659   with creation of pericardial window or partial resection of pericardial sac for drainage
32661   with excision of pericardial cyst, tumor, or mass
32662   with excision of mediastinal cyst, tumor, or mass
32663   with lobectomy (single lobe)
32664   with thoracic sympathectomy
32665   with esophagomyotomy (Heller type)
32666   with therapeutic wedge resection (eg, mass, nodule), initial unilateral
32667   with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral
   (List separately in addition to primary code)
   (Report 32667 only in conjunction with 32666)
32668   with diagnostic wedge resection followed by anatomic lung resection
(List separately in addition to primary code)
(Report 32668 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32663, 32669, 32670, 32671)

32669  with removal of a single lung segment (segmentectomy)
32670  with removal of two lobes (bilobectomy)
32671  with removal of lung (pneumonectomy)
32672  with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed
32673  with resection of thymus, unilateral or bilateral
32674  with mediastinal and regional lymphadenectomy
(Report 32674 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32663, 32666, 32667, 32669, 32670, 32671)

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

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

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

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

OTHER PROCEDURES
32997  Total lung lavage (unilateral)
32998  Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency
CARDIOVASCULAR SYSTEM

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

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

HEART AND PERICARDIUM

PERICARDIUM

33010 Pericardiocentesis; initial
33011 subsequent
33015 Tube pericardiostomy
33020 Pericardiectomy for removal of clot or foreign body (primary procedure)
33025 Creation of pericardial window or partial resection for drainage
33030 Pericardiectomy, subtotal or complete; without cardiopulmonary bypass
33031 with cardiopulmonary bypass
33050 Resection of pericardial cyst or tumor

CARDIAC TUMOR

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

TRANSMYOCARDIAL REVASCULARIZATION

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

PACEMAKER OR PACING CARDIOVERTER-DEFIBRILLATOR

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

Electrodes may be inserted through a vein (transvenous) or they may be placed on the surface of the heart (epicardial). The epicardial location of electrodes requires a thoracotomy for electrode insertion.
A single chamber pacemaker system includes a pulse generator and one electrode inserted in either the atrium or ventricle. A dual chamber pacemaker system includes a pulse generator and one electrode inserted in the right atrium and one electrode inserted in the right ventricle. In certain circumstances, an additional electrode may be required to achieve pacing of the left ventricle (bi-ventricular pacing). In this event, transvenous (cardiac vein) placement of the electrode should be separately reported using code 33224 or 33225. Epicardial placement of the electrode should be separately reported using 33202-33203.

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

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

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

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

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

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

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

33202 Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach)
33203  endoscopic approach (eg, thoracoscopy, pericardioscopy)
(When epicardial lead placement is performed by the same physician at the same session as
insertion of the generator, report 33202, 33203 in conjunction with 33212, 33213, as
appropriate)
33206  Insertion of new or replacement of permanent pacemaker with transvenous electrode(s);
atrial
33207  ventricular
33208  atrial and ventricular
(Codes 33206-33208 include subcutaneous insertion of the pulse generator and transvenous
placement of electrode(s))
33210  Insertion or replacement of temporary transvenous single chamber cardiac electrode or
pacemaker catheter (separate procedure)
33211  Insertion or replacement of temporary transvenous dual chamber pacing electrodes
(separate procedure)
33212  Insertion of pacemaker pulse generator only; with existing single lead
33213  with existing dual leads
(When epicardial lead placement is performed with insertion of generator, report 33202,
33203 in conjunction with 33212, 33213)
33214  Upgrade of implanted pacemaker system, conversion of single chamber system to dual
chamber system (includes removal of previously placed pulse generator, testing of existing
lead, insertion of new lead, insertion of new pulse generator)
(Do not report 33214 in conjunction with 33227-33229)
33215  Repositioning of previously implanted transvenous pacemaker or implantable
defibrillator (right atrial or right ventricular) electrode
33216  Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator
33217  Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator
33218  Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator
33220  Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator
33221  Insertion of pacemaker pulse generator only; with existing multiple leads
33222  Relocation of skin pocket for pacemaker
33223  Relocation of skin pocket for implantable defibrillator
33224  Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with
attachment to previously placed pacemaker or implantable defibrillator pulse generator
(including revision of pocket, removal, insertion, and/or replacement of existing generator)
(When epicardial electrode placement is performed, report 33224 in conjunction with 33202,
33203)
33225  Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of
insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual
chamber system) (List separately in addition to primary procedure)
(Use 33225 in conjunction with 33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217,
33221, 33223, 33228, 33229, 33230, 33231, 33233, 33234, 33235, 33240, 33249, 33263,
33264)
33226  Repositioning of previously implanted cardiac venous system (left ventricular) electrode
(including removal, insertion and/or replacement of existing generator)
33227  Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system
   dual lead system
   multiple lead system
   (Do not report 33227-33229 in conjunction with 33233)
33230  Insertion of implantable defibrillator pulse generator with existing dual leads
   with existing multiple leads
   (Do not report 33230, 33231, 33240 in conjunction with 33241 for removal and replacement of the pacing cardioverter-defibrillator pulse generator. Use 33262-33264, as appropriate, when pulse generator replacement is indicated)
33233  Removal of permanent pacemaker pulse generator only
33234  Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular
   dual lead system
33236  Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular
   dual lead system
33238  Removal of permanent transvenous electrode(s) by thoracotomy
33240  Insertion of implantable defibrillator pulse generator only; with existing single lead
   (Use 33240, as appropriate, in addition to the epicardial lead placement codes to report the insertion of the generator when done by the same physician during the same session)
33241  Removal of implantable defibrillator pulse generator only
33243  Removal of single or dual chamber implantable defibrillator electrode(s); by thoracotomy
   by transverse extraction
33249  Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber
33262  Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system
   dual lead system
   multiple lead system
33270  Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed
33271  Insertion of subcutaneous implantable defibrillator electrode
33272  Removal of subcutaneous implantable defibrillator electrode
33273  Repositioning of previously implanted subcutaneous implantable defibrillator electrode

**ELECTROPHYSIOLOGIC OPERATIVE PROCEDURES**

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

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

DEFINITIONS:

**Limited operative ablation and reconstruction includes:**

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

**Extensive operative ablation and reconstruction includes:**

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

INCISION

- 33250 Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); without cardiopulmonary bypass
- 33251 with cardiopulmonary bypass
- 33254 Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)
- 33255 Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass
- 33256 with cardiopulmonary bypass
- 33257 Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to primary procedure)
- 33258 Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to primary procedure)
- 33259 Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to primary procedure)
- 33261 Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass
- 33263 dual lean system
- 33264 multiple lead system

ENDOSCOPY

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

**SUBCUTANEOUS CARDIAC RHYTHM MONITOR**

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

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

**WOUNDS OF THE HEART AND GREAT VESSELS**

33300 Repair of cardiac wound; without bypass
33305 with cardiopulmonary bypass
33310 Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); without bypass
33315 with cardiopulmonary bypass
33320 Suture repair of aorta or great vessels; without shunt or cardiopulmonary bypass
33321 with shunt bypass
33322 with cardiopulmonary bypass
33330 Insertion of graft, aorta or great vessels; without shunt, or cardiopulmonary bypass
33335 with cardiopulmonary bypass

**CARDIAC VALVES**

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

AORTIC VALVE

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

MITRAL VALVE

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

TRICUSPID VALVE

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

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

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

OTHER VALVULAR PROCEDURES

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

CORONARY ARTERY ANOMALIES

Basic procedures include endarterectomy or angioplasty.

33500  Repair of coronary arteriovenous or arteriocardiac chamber fistula; with cardio-pulmonary bypass
33501  without cardio-pulmonary bypass
33502  Repair of anomalous coronary artery from pulmonary artery origin; by ligation
33503  by graft, without cardiopulmonary bypass
33504  by graft, with cardiopulmonary bypass
33505  with construction of intrapulmonary artery tunnel (Takeuchi procedure)
33506  by translocation from pulmonary artery to aorta
33507  Repair of anomalous (eg, intramural) aortic origin of coronary artery by unroofing or translocation

ENDOSCOPY

Surgical vascular endoscopy always includes diagnostic endoscopy.

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

VENOUS GRAFTING ONLY FOR CORONARY ARTERY BYPASS

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

See 33517-33523 and 33533-33536 for reporting combined arterial-venous grafts.
Procurement of the saphenous vein graft is included in the description of the work for 33510-33516 and should not be reported as a separate service or co-surgery. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure.

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

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

COMBINED ARTERIAL-VENOUS GRAFTING FOR CORONARY BYPASS

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

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

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

33517 Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft
   (List separately in addition to primary procedure)
   (Use 33517 in conjunction with 33533-33536)
   two venous grafts
      (List separately in addition to primary procedure)
      (Use 33518 in conjunction with 33533-33536)
   three venous grafts
      (List separately in addition to primary procedure)
      (Use 33519 in conjunction with 33533-33536)
   four venous grafts
      (List separately in addition to primary procedure)
      (Use 33521 in conjunction with 33533-33536)
   five venous grafts
      (List separately in addition to primary procedure)
      (Use 33522 in conjunction with 33533-33536)
33523  six or more venous grafts
   (List separately in addition to primary procedure)
   (Use 33523 in conjunction with 33533-33536)

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

**ARTERIAL GRAFTING FOR CORONARY ARTERY BYPASS**

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

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

Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 35600 in addition to the bypass procedure. To report harvesting of an upper extremity vein, use 33500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 33572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier -80 to 33517-33523, 33533-33536 as appropriate.

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

**CORONARY ENDARTERECTOMY**

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

**SINGLE VENTRICLE AND OTHER COMPLEX CARDIAC ANOMALIES**

(Do not report modifier –63 in conjunction with 33610, 33611 or 33619)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33600</td>
<td>Closure of atroventricular valve (mitral or tricuspid) by suture or patch</td>
</tr>
<tr>
<td>33602</td>
<td>Closure of semilunar valve (aortic or pulmonary) by suture or patch</td>
</tr>
<tr>
<td>33606</td>
<td>Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure)</td>
</tr>
<tr>
<td>33608</td>
<td>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</td>
</tr>
<tr>
<td>33610</td>
<td>Repair of complex cardiac anomalies (eg, single ventricle with subaortic obstruction) by surgical enlargement of ventricular septal defect</td>
</tr>
<tr>
<td>33611</td>
<td>Repair of double outlet right ventricle with intraventricular tunnel repair;</td>
</tr>
<tr>
<td>33612</td>
<td>with repair of right ventricular outflow tract obstruction</td>
</tr>
<tr>
<td>33615</td>
<td>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)</td>
</tr>
<tr>
<td>33617</td>
<td>Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure</td>
</tr>
<tr>
<td>33619</td>
<td>Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)</td>
</tr>
<tr>
<td>33620</td>
<td>Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)</td>
</tr>
<tr>
<td>33621</td>
<td>Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)</td>
</tr>
<tr>
<td>33622</td>
<td>Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding) (Do not report 33622 in conjunction with 33619, 33767, 33822, 33840, 33845, 33851, 33853, 33917)</td>
</tr>
</tbody>
</table>

**SEPTAL DEFECT**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33641</td>
<td>Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch</td>
</tr>
<tr>
<td>33645</td>
<td>Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage</td>
</tr>
<tr>
<td>33647</td>
<td>Repair of atrial septal defect and ventricular septal defect, with direct or patch closure</td>
</tr>
<tr>
<td>33660</td>
<td>Repair of incomplete or partial atroventricular canal (ostium primum atrial septal defect), with or without atroventricular valve repair</td>
</tr>
<tr>
<td>33665</td>
<td>Repair of intermediate or transitional atroventricular canal, with or without atroventricular valve repair</td>
</tr>
<tr>
<td>33670</td>
<td>Repair of complete atroventricular canal, with or without prosthetic valve</td>
</tr>
<tr>
<td>33675</td>
<td>Closure of multiple ventricular septal defects;</td>
</tr>
<tr>
<td>33676</td>
<td>with pulmonary valvotomy or infundibular resection (acyanotic)</td>
</tr>
<tr>
<td>33677</td>
<td>with removal of pulmonary artery band, with or without gusset</td>
</tr>
<tr>
<td>33681</td>
<td>Closure of single ventricular septal defect, with or without patch;</td>
</tr>
<tr>
<td>33684</td>
<td>with pulmonary valvotomy or infundibular resection (acyanotic)</td>
</tr>
<tr>
<td>33688</td>
<td>with removal of pulmonary artery band, with or without gusset</td>
</tr>
<tr>
<td>33690</td>
<td>Banding of pulmonary artery</td>
</tr>
<tr>
<td>33692</td>
<td>Complete repair tetralogy of Fallot without pulmonary atresia;</td>
</tr>
</tbody>
</table>
33694  with transannular patch
33697  Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect

SINUS OF VALSALVA

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

VENOUS ANOMALIES

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

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

SHUNTING PROCEDURES

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

33735  Atrial septectomy or septostomy; closed heart (Blalock-Hanlon type operation)
33736  open heart with cardiopulmonary bypass
33737  open heart, with inflow occlusion
33750  Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation)
33755  ascending aorta to pulmonary artery (Waterston type operation)
33762  descending aorta to pulmonary artery (Potts-Smith type operation)
33764  central, with prosthetic graft
33766  superior vena cava to pulmonary artery for flow to one lung (classical Glenn procedure)
33767  superior vena cava to pulmonary artery for flow to both lungs (bidirectional Glenn procedure)
33768  Anastomosis, cavopulmonary, second superior vena cava
   (List separately in addition to primary procedure)

TRANSPOSITION OF THE GREAT VESSELS

33770  Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect
33771  with surgical enlargement of ventricular septal defect
33774  Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass;
33775  with removal of pulmonary band
33776 with closure of ventricular septal defect
33777 with repair of subpulmonic obstruction
33778 Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type) 
   (Do not report modifier –63 in conjunction with 33778) 
33779 with removal of pulmonary band 
33780 with closure of ventricular septal defect 
33781 with repair of subpulmonic obstruction 
33782 Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation 
33783 with reimplantation of 1 or both coronary ostia 

TRUNCUS ARTERIOSUS 

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

AORTIC ANOMALIES 

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

THORACIC AORTIC ANEURYSM 

33860 Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed 
33863 with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall) 
33864 with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure) 
33866 Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory
arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)

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.

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

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

33880 Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin
33881 not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin
33883 Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension
(Do not report 33881, 33883 when extension placement converts repair to cover left subclavian origin. use only 33880)
33884 each additional proximal extension
(List separately in addition to primary procedure)
(Use 33884 in conjunction with 33883)
33886 Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta
(Do not report 33886 in conjunction with 33880, 33881)
(Report 33886 once, regardless of number of modules deployed)
33889 Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral
(Do not report 33889 in conjunction with 35694)
33891 Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision
(Do not report 33891 in conjunction with 35509, 35601)

**PULMONARY ARTERY**

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

**HEART/LUNG TRANSPLANTATION**

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

**EXTRACORPOREAL MEMBRANE OXYGENATION or EXTRACORPOREAL LIFE SUPPORT SERVICES**

33946 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous
33947 initiation veno-arterial
33948 daily management, each day, veno-venous
33949 daily management, each day, veno-arterial
33951 insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>33952</td>
<td>insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)</td>
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<tr>
<td>33953</td>
<td>insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age</td>
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<tr>
<td>33954</td>
<td>insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older</td>
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<td>33955</td>
<td>insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age</td>
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<tr>
<td>33956</td>
<td>insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older</td>
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<td>33957</td>
<td>reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)</td>
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<td>reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)</td>
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<td>33959</td>
<td>reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance when performed)</td>
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<td>33962</td>
<td>reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)</td>
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<td>33963</td>
<td>reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)</td>
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<td>33964</td>
<td>reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)</td>
</tr>
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<td>33965</td>
<td>removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age</td>
</tr>
<tr>
<td>33966</td>
<td>removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older</td>
</tr>
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<td>33969</td>
<td>removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age</td>
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<td>33984</td>
<td>removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older</td>
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<td>33985</td>
<td>removal of central cannula(e), by sternotomy or thoracotomy, birth through 5 years of age</td>
</tr>
<tr>
<td>33986</td>
<td>removal of central cannula(e), by sternotomy or thoracotomy, 6 years and older</td>
</tr>
<tr>
<td>33987</td>
<td>Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>33988</td>
<td>Insertion of left heart vent by thoracic incision (eg, sternotomy/thoracotomy) for ECMO/ECLS</td>
</tr>
<tr>
<td>33989</td>
<td>Removal of left heart vent by thoracic incision (eg, sternotomy/thoracotomy) for ECMO/ECLS</td>
</tr>
</tbody>
</table>
CARCIA ASSIST

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

OTHER PROCEDURES

33999  Unlisted procedure, cardiac surgery

ARTERIES AND VEINS

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

EMBOLECTOMY/THROMBECTOMY

ARTERIAL, WITH OR WITHOUT CATHETER

34001  Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate
artery, by neck incision
34051 innominate, subclavian artery, by thoracic incision
34101 axillary, brachial, innominate, subclavian artery, by arm incision
34111 radial or ulnar artery, by arm incision
34151 renal, celiac, mesentery, aortoiliac artery, by abdominal incision
34201 femoropopliteal, aortoiliac artery, by leg incision
34203 popliteal-tibio-peroneal, by leg incision

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

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

ENDOVASCULAR REPAIR OF ABDOMINAL AORTA AND/OR ILIAC ARTERIES

34701 Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer)
34702 for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)
34703 Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uniliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer)
34704 for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)
34705 Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the
Physician - Procedure Codes, Section 5 - Surgery

level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)

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

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

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

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

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

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

34712 Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation

34713 Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French of larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)

34714 Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)

34715 Open axillary/subclavian exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)

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

34808 Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)

34812 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

34813 Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair
(List separately in addition to primary procedure)
(Use 34813 in conjunction with code 34812)

34820 Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)

34830 Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis

34831 aorto-bi-iliac prosthesis
34832 aorto-bifemoral prosthesis

34833 Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)

34834 Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)

34715 Open axillary/subclavian exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)

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

FENESTRATED ENDOVASCULAR REPAIR of the VISCERAL and INFRARENAL AORTA

34841 Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneuysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)

34842 including two visceral artery endoprosthesis (superior mesenteric, celiac and/or renal artery[s])
34843 including three visceral artery endoprosthesis (superior mesenteric, celiac and/or renal artery[s])
34844 including four or more visceral artery endoprosthesis (superior mesenteric, celiac and/or renal artery[s])

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

34846 including two visceral artery endoprosthesis (superior mesenteric, celiac or renal artery[s])
34847 including three visceral artery endoprosthesis (superior mesenteric, celiac and/or renal artery[s])
DIRECT REPAIR OF ANEURYSM OR EXCISION (PARTIAL OR TOTAL) AND GRAFT INSERTION FOR ANEURYSM, PSEUDOANEURYSM, RUPTURED ANEURYSM, AND ASSOCIATED OCCLUSIVE DISEASE

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

35001 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, carotid, subclavian artery, by neck incision
35002 for ruptured aneurysm, carotid, subclavian artery, by neck incision
35005 for aneurysm, pseudoaneurysm, and associated occlusive disease, vertebral artery
35011 for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision
35013 for ruptured aneurysm, axillary-brachial artery, by arm incision
35021 for aneurysm, pseudoaneurysm, and associated occlusive disease, innominate, subclavian artery, by thoracic incision
35022 for ruptured aneurysm, innominate, subclavian artery, by thoracic incision
35045 for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery
35081 for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta
35082 for ruptured aneurysm, abdominal aorta
35091 for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)
35092 for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)
35102 for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)
35103 for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)
35111 for aneurysm, pseudoaneurysm, and associated occlusive disease, splenic artery
35112 for ruptured aneurysm, splenic artery
35121 for aneurysm, pseudoaneurysm, and associated occlusive disease, hepatic, celiac, renal or mesenteric artery
35122 for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery
35131 for aneurysm, pseudoaneurysm, and associated occlusive disease, iliac artery (common, hypogastric, external)
35132 for ruptured aneurysm, iliac artery (common, hypogastric, external)
35141 for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)
35142 for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral)
35151 for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery
35152 for ruptured aneurysm, popliteal artery

REPAIR ARTERIOVENOUS FISTULA

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

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

35201 Repair blood vessels, direct; neck
35206 upper extremity
35207 hand, finger
35211 intrathoracic, with bypass
35216 intrathoracic, without bypass
35221 intra-abdominal
35226 lower extremity
35231 Repair blood vessel with vein graft; neck
35236 upper extremity
35241 intrathoracic, with bypass
35246 intrathoracic, without bypass
35251 intra-abdominal
35256 lower extremity
35261 Repair blood vessel with graft other than vein; neck
35266 upper extremity
35271 intrathoracic, with bypass
35276 intrathoracic, without bypass
35281 intra-abdominal
35286 lower extremity

**THROMBOENDARTERECTOMY**

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

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

ANGIOSCOPY

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

TRANSLUMINAL ANGIOPLASTY

OPEN

PERCUTANEOUS

BYPASS GRAFT

VEIN

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

35500  Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass
   procedure
   (List separately in addition to primary procedure)
   (Use 35500 in conjunction with 33510-33536, 35556, 35566, 35571, 35583-35587)
35501  Bypass graft, with vein; common carotid-ipsilateral internal carotid
35506  carotid-subclavian or subclavian-carotid
35508  carotid-vertebral
35509  carotid-contralateral carotid
35510  carotid-brachial
35511  subclavian-subclavian
35512  subclavian-brachial
35515  subclavian-vertebral
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<td>35516</td>
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<td>axillary-axillary</td>
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<td>axillary-femoral</td>
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<td>35522</td>
<td>axillary-brachial</td>
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<tr>
<td>35523</td>
<td>brachial-ulnar or -radial</td>
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<td>(Do not report 35523 in conjunction with 35206, 35500, 35525, 36838)</td>
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<tr>
<td>35525</td>
<td>brachial-brachial</td>
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<tr>
<td>35526</td>
<td>aortosubclavian, aortoinnominate, or aortocarotid</td>
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<tr>
<td>35531</td>
<td>aortoceliac or aortomesenteric</td>
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<td>axillary-femoral-femoral</td>
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<td>aortofemoral</td>
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<td>aortobifemoral</td>
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<td>35556</td>
<td>femoral-popliteal</td>
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<tr>
<td>35560</td>
<td>aortorenal</td>
</tr>
<tr>
<td>35563</td>
<td>ilioiliac</td>
</tr>
<tr>
<td>35565</td>
<td>iliofemoral</td>
</tr>
<tr>
<td>35566</td>
<td>femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels</td>
</tr>
<tr>
<td>35570</td>
<td>tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial</td>
</tr>
<tr>
<td></td>
<td>(Do not report 35570 in conjunction with 35256, 35286)</td>
</tr>
<tr>
<td>35571</td>
<td>popliteal-tibial, -peroneal artery or other distal vessels</td>
</tr>
<tr>
<td>35572</td>
<td>Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery)</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(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)</td>
</tr>
<tr>
<td></td>
<td>(For bilateral procedure, use modifier -50)</td>
</tr>
</tbody>
</table>

**IN SITU VEIN**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>35583</td>
<td>In-situ vein bypass; femoral-popliteal</td>
</tr>
<tr>
<td>35585</td>
<td>femoral-anterior tibial, posterior tibial, or peroneal artery</td>
</tr>
<tr>
<td>35587</td>
<td>popliteal-tibial, perineal</td>
</tr>
</tbody>
</table>

**OTHER THAN VEIN**
35600  Harvest of upper extremity artery, one segment, for coronary artery bypass procedure  
(List separately in addition to primary procedure)  
(Use 35600 in conjunction with 33533-33536)

35601  Bypass graft, with other than vein; common carotid-ipsilateral internal carotid
35606   carotid-subclavian
35612   subclavian-subclavian
35616   subclavian-axillary
35621   axillary-femoral
35623   axillary-popliteal or -tibial
35626   aortosubclavian, aortoinnominate, or aortocarotid
35631   aortoceliac, aortomesenteric, aortorenal
35632   ilio-celiac
          (Do not report 35632 in conjunction with 35221, 35251, 35281, 35531, 35631)
35633   ilio-mesenteric
          (Do not report 35633 in conjunction with 35221, 35251, 35281, 35531, 35631)
35634   iliorenal
          (Do not report 35634 in conjunction with 35221, 35251, 35281, 35560, 35536, 35631)
35636   splenorenal (splenic to renal arterial anastomosis)
35637   aortoiliac
          (Do not report 35637 in conjunction with 35638, 35646)
35638   aortobi-iliac
          (Do not report 35638 in conjunction with 35637, 35646)
35642   carotid-vertebral
35645   subclavian-vertebral
35646   aortobifemoral
35647   aortofemoral
35650   axillary-axillary
35654   axillary-femoral-femoral
35656   femoral-popliteal
35661   femoral-femoral
35663   iliolumbar
35665   iliofemoral
35666   femoral-anterior tibial, posterior tibial, or peroneal artery
35671   popliteal-tibial, or -peroneal artery

**COMPOSITE GRAFTS**

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

35681  Bypass graft; composite, prosthetic and vein  
(List separately in addition to primary procedure)
35682   autogenous composite, two segments of veins from two locations
(List separately in addition to primary procedure)

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

ADJUVANT TECHNIQUES

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

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

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

35686 Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis)
(List separately in addition to primary procedure)
(Use 35686 in conjunction with codes 35556, 35566, 35571, 35583-35587, 35623, 35656, 35666, 35671)

ARTERIAL TRANSPOSITION

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

EXCISION, EXPLORATION, REPAIR, REVISION

35700 Reoperation, femoral-popliteal or femoral (popliteal) -anterior tibial, posterior tibial, peroneal artery or other distal vessels, more than one month after original operation
(List separately in addition to primary procedure)
(Use 35700 in conjunction with 35556, 35566, 35571, 35583, 35585, 35587, 35656, 35666, 35671)

35701 Exploration (not followed by surgical repair), 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
35879  Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch
35881  with segmental vein interposition
35883  Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with
35884  with autogenous vein patch graft
35901  Excision of infected graft; neck
35903  extremity
35905  thorax
35907  abdomen

**VASCULAR INJECTION PROCEDURES**

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

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

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

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

**INTRAVENOUS**

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

**INTRA ARTERIAL---INTRA-AORTIC**

36100  Introduction of needle or intracatheter, carotid or vertebral artery
36140  Introduction of needle or intracatheter, upper or lower extremity artery
36160  Introduction of needle or intracatheter, aortic, translumbar
36200  Introduction of catheter, aorta
36215  Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family
36216    initial second order thoracic or brachiocephalic branch, within a vascular family
36217    initial third order or more selective thoracic or brachiocephalic branch, within a vascular family
36218    additional second order, third order and beyond, thoracic or brachiocephalic branch, within a vascular family
            (List in addition to code for initial second or third order vessel as appropriate)
            (Use 36218 in conjunction with 36216, 36217)
36221  Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

            (Do not report 36221 with 36222-36226)
36222  Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
36223  Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
36224  Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
36225 Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36226 Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36227 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation
(List separately in addition to primary procedure)
(Use 36227 in conjunction with 36222, 36223, or 36224)

36228 Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery)
(List separately in addition to primary procedure)
(Use 36228 in conjunction with 36224 or 36226)
(Do not report 36228 more than twice per side)

36245 Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family

36246 initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family

36247 initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family

36248 additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family
(List in addition to code for initial second or third order vessel as appropriate)
(Use 36248 in conjunction with 36246, 36247)

36251 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

36252 bilateral

36253 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral
(Do not report 36253 in conjunction with 36251 when performed for the same kidney)

36254 bilateral

36260 Insertion of implantable intra-arterial infusion pump (eg, for chemotherapy of liver)

36261 Revision of implanted intra-arterial infusion pump

36262 Removal of implanted intra-arterial infusion pump
36299  Unlisted procedure, vascular injection

VENOUS

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

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

36400  Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein
36405    scalp vein
36406    other vein
36410  Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)

36420  Venipuncture, cutdown; younger than age 1 year
36425    age 1 or over (Not to be used for routine venipuncture)
36430  Transfusion, blood or blood components
36440  Push transfusion, blood, 2 years or younger
36450  Exchange transfusion, blood; newborn
36455    other than newborn
36456  Partial exchange transfusion, blood, plasma or crystalloid necessitating the skill of a physician or other qualified healthcare professional, newborn
36460  Transfusion, intrauterine, fetal
36465  Injection(s) of sclerosant for spider veins (telangiectasia); limb or trunk
36470  Injection of sclerosant; single incompetent vein (other than telangiectasia)
36471    multiple incompetent veins (other than telangiectasia), same leg
36465  Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)
36466    multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg
36475  Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476    subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) (Use 36476 in conjunction with 36475)
36478  Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479    subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) (Use 36479 in conjunction with 36478)
36478, 36479 are an alternative to standard open stripping and ligation procedure, covered for refractory leg ulcers due to saphenous vein incompetence, or recurrent or significant bleeding from a varicosity.

36481  Percutaneous portal vein catheterization by any method
36500  Venous catheterization for selective organ blood sampling
36510  Catheterization of umbilical vein for diagnosis or therapy, newborn
36511  Therapeutic apheresis; for white blood cells
36512   for red blood cells
36513   for platelets
36514   for plasma pheresis
36516   with extracorporeal immunoabsorption, selective absorption or selective filtration and plasma reinfusion
36522  Photopheresis, extracorporeal

CENTRAL VENOUS ACCESS PROCEDURES

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

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

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

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

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

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

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

**INSERTION OF CENTRAL VENOUS ACCESS DEVICE**
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36555</td>
<td>Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age</td>
</tr>
<tr>
<td>36556</td>
<td>age 5 years or older</td>
</tr>
<tr>
<td>36557</td>
<td>Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age</td>
</tr>
<tr>
<td>36558</td>
<td>age 5 years or older</td>
</tr>
<tr>
<td>36559</td>
<td>Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; under 5 years of age</td>
</tr>
<tr>
<td>36560</td>
<td>age 5 years or older</td>
</tr>
<tr>
<td>36561</td>
<td>Insertion of tunneled centrally inserted central venous access device with subcutaneous pump</td>
</tr>
<tr>
<td>36562</td>
<td>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)</td>
</tr>
<tr>
<td>36563</td>
<td>With subcutaneous port(s)</td>
</tr>
<tr>
<td>36564</td>
<td>Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age</td>
</tr>
<tr>
<td>36565</td>
<td>age 5 years or older</td>
</tr>
<tr>
<td>36566</td>
<td>Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age</td>
</tr>
<tr>
<td>36567</td>
<td>age 5 years or older</td>
</tr>
<tr>
<td>36568</td>
<td>Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age</td>
</tr>
<tr>
<td>36569</td>
<td>age 5 years or older</td>
</tr>
</tbody>
</table>

**REPAIR OF CENTRAL VENOUS ACCESS DEVICE**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36575</td>
<td>Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site</td>
</tr>
<tr>
<td>36576</td>
<td>Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site</td>
</tr>
</tbody>
</table>

**PARTIAL REPLACEMENT OF CENTRAL VENOUS ACCESS DEVICE (CATHETER ONLY)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36578</td>
<td>Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36580</td>
<td>Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access</td>
</tr>
<tr>
<td>36581</td>
<td>Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access</td>
</tr>
</tbody>
</table>
36582  Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access

36583  Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access

36584  Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement

36585  Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access

REMOVAL OF CENTRAL VENOUS ACCESS DEVICE

36589  Removal of tunneled central venous catheter, without subcutaneous port or pump

36590  Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion
(Do not report 36589 or 36590 for removal of non-tunneled central venous catheters)

OTHER CENTRAL VENOUS ACCESS PROCEDURES

36591  Collection of blood specimen from a completely implantable venous access device
(Do not report 36591 in conjunction with any other service)

36593  Declotting by thrombolytic agent of implanted vascular access device or catheter

36595  Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access
(Do not report 36595 in conjunction with 36593)

36596  Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen
(Do not report 36596 in conjunction with 36593)

36597  Repositioning of previously placed central venous catheter under fluoroscopic guidance

36598  Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report
(Do not report 36598 in conjunction with 36595, 36596)
(Do not report 36598 in conjunction with 76000)

ARTERIAL

36600  Arterial puncture, withdrawal of blood for diagnosis

36620  Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
cutdown

36640  Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown
(See also 96420-96425)

36660  Catheterization, umbilical artery, newborn, for diagnosis or therapy
(Do not report modifier 63 in conjunction with 36660)
INTRAOSSEOUS

36680 Placement of needle for intraosseous infusion

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

36800 Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein arteriovenous, external (Scribner type)
36810 arteriovenous, external revision or closure
36818 Arteriovenous anastomosis, open; by upper arm cephalic vein transposition (Do not report 36818 in conjunction with 36819, 36820, 36821, 36830 during a unilateral upper extremity procedure. For bilateral upper extremity open arteriovenous anastomoses performed at the same operative session, use modifier -50)
36819 by upper arm basilic vein transposition (Do not report 36819 in conjunction with 36818, 36820, 36821, 36830 during a unilateral upper extremity procedure. For bilateral upper extremity open arteriovenous anastomoses performed at the same operative session, use modifier -50)
36820 by forearm vein transposition
36821 direct, any site (eg. Cimino type) (separate procedure)
36823 Insertion of arterial and venous cannula(s) for isolated extracorporeal circulation including regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy and venotomy sites (36823 includes chemotherapy perfusion supported by a membrane oxygenator/perfusion pump. Do not report 96409-96425 in conjunction with 36823)
36825 Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft
36830 nonautogenous graft (eg, biological collagen, thermoplastic graft)
36831 Thrombectomy, open, arteriovenous fistula without revision, autogenous or non-autogenous dialysis graft (separate procedure)
36832 Revision, open, arteriovenous fistula; without thrombectomy, autogenous or non-autogenous dialysis graft (separate procedure)
36833 with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
36835 Insertion of Thomas shunt (separate procedure)
36838 Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome) (Do not report 36838 in conjunction with 35512, 35522, 36832, 37607, 37618)
36860 External cannula declotting (separate procedure); without balloon catheter
36861 with balloon catheter

DIALYSIS CIRCUIT

36901 Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of
contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;
36902 with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty
36903 with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment
36904 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);
36905 with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty
36906 with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment
36907 Transluminal balloon angioplasty, central dialysis segment, performed though dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty
(List separately in addition to code for primary procedure)
36908 Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment
(List separately in addition to code for primary procedure)
36909 Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention
(List separately in addition to code for primary procedure)

PORTAL DECOMPRESSION PROCEDURES
37140 Venous anastomosis, open; portocaval
37145 renoportal
37160 caval mesenteric
37180 splenorenal, proximal
37181 splenorenal, distal (selective decompression of esophagogastric varices, any technique)
37182 Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation
(Do not report 75885 or 75887 in conjunction with 37182)
37183  Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilation, stent placement and all associated imaging guidance and documentation)  
(Do not report 75885 or 75887 in conjunction with code 37183)

**TRANSCATHETER PROCEDURES**

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

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

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

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

For coronary mechanical thrombectomy, use 92973.

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

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

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

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

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

**ARTERIAL MECHANICAL THROMBECTOMY**

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

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

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

**VENOUS MECHANICAL THROMBECTOMY**

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

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

**OTHER PROCEDURES**

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

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

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

37195 Thrombolysis, cerebral, by intravenous infusion

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

37200 Transcatheter biopsy

37211 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day
37212 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day

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

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

(Report 37211 – 37214 once per date of treatment)

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

37216 without distal embolic protection

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

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

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

ILIAC ARTERY REVASCULARIZATION

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

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

37222 Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty

(List separately in addition to primary procedure)

(Use 37222 in conjunction with 37220, 37221)

37223 with transluminal stent placement(s), includes angioplasty within the same vessel, when performed

(List separately in addition to primary procedure)

(Use 37223 in conjunction with 37221)

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

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

37226 with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
37227  with transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel, when performed

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

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

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

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

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

37233  with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to primary procedure) (Use 37233 in conjunction with 37229-37231)

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

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

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

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

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

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

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

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

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

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

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

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

**VASCULAR EMBOLIZATION AND OCCLUSION**

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

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

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

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

37243  for tumors, organ ischemia, of infarction

37244  for arterial of venous hemorrhage or lymphatic extravasation

**INTRAVASCULAR ULTRASOUND SERVICES**

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

Vascular access for intravascular ultrasound performed during a therapeutic intervention is not reported separately.
37252 Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial vessel noncoronary vessel
(List separately in addition to primary procedure)
37253 each additional noncoronary vessel
(List separately in addition to primary procedure)
(Use 37253 in conjunction with 37252)

ENDOSCOPY

Surgical vascular endoscopy always includes diagnostic endoscopy.

37500 Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)
37501 Unlisted vascular endoscopy procedure

LIGATION

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

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

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

HEMIC AND LYMPHATIC SYSTEMS

SPLEEN

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

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

LAPAROSCOPY
Surgical laparoscopy always includes diagnostic laparoscopy.
38120 Laparoscopy, surgical, splenectomy
38129 Unlisted laparoscopy procedure, spleen

INTRODUCTION
38200 Injection procedure for splenoportography

GENERAL

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

LYMPH NODES AND LYMPHATIC CHANNELS

INCISION
38300 Drainage of lymph node abscess or lymphadenitis; simple
38305  extensive
38308 Lymphangiotomy or other operations on lymphatic channels
38380 Suture and/or ligation of thoracic duct; cervical approach
38381  thoracic approach
38382  abdominal approach

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

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

LAPAROSCOPY
Surgical laparoscopy always includes diagnostic laparoscopy.
38570 Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple
38571  with bilateral total pelvic lymphadenectomy
38572  with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy) single or multiple
38573  with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling, peritoneal washings, peritoneal biopsy(ies), omentectomy, and diaphragmatic washings, including diaphragmatic and other serosal biopsy(ies), when performed

38589  Unlisted laparoscopy procedure, lymphatic system

RADICAL LYMPHADENECTOMY (RADICAL RESECTION OF LYMPH NODES)

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

38700  Suprahyoid lymphadenectomy
38720  Cervical lymphadenectomy (complete)
38724  Cervical lymphadenectomy (modified radical neck dissection)
38740  Axillary lymphadenectomy; superficial
38745  complete
38746  Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy
(List separately in addition to primary procedure)
(Report 38746 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32505)
38747  Abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para aortic and vena caval nodes
(List separately in addition to primary procedure)
38760  Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)
38765  Inguinofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)
38770  Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)
38780  Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)

INTRODUCTION

38790  Injection procedure; lymphangiography
(For bilateral procedure, report 38790 with modifier -50)
38792  radioactive tracer for identification of sentinel node
38794  Cannulation, thoracic duct

OTHER PROCEDURES

38900  Intraoperative identification (eg, mapping) of sentinel lymph node(s), includes injection of non-radioactive dye, when performed
(List separately in addition to primary procedure)
(Use 38900 in conjunction with 19302, 19307, 38500, 38510, 38520, 38530, 38542, 38740, 38745)
38999  Unlisted procedure, hemic or lymphatic system

MEDIASTINUM AND DIAPHRAGM
**MEDIASTINUM**

**INCISION**

39000  Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; cervical approach
39010  transthoracic approach, including either transthoracic or median sternotomy

**EXCISION/RESECTION**

39200  Resection of mediastinal cyst
39220  Resection of mediastinal tumor

**ENDOSCOPY**

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

**OTHER PROCEDURES**

39499  Unlisted procedure, mediastinum

**DIAPHRAGM**

**REPAIR**

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

**OTHER PROCEDURES**

39599  Unlisted procedure, diaphragm

**DIGESTIVE SYSTEM**

**LIPS**

**EXCISION**

40490  Biopsy of lip
40500  Vermilionectomy (lip shave), with mucosal advancement
40510  Excision of lip; transverse wedge excision with primary closure

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Version 2019
40520  V-excision with primary direct linear closure
40525  full thickness, reconstruction with local flap (eg, Estlander or fan)
40527  full thickness, reconstruction with cross lip flap (Abbe-Estlander)
40530  Resection lip, more than one-fourth, without reconstruction

REPAIR (CHEILOPTASY)

40650  Repair lip, full thickness; vermilion only
40652  up to half vertical height
40654  over one-half vertical height, or complex
40700  Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral
40701  primary bilateral, one stage procedure
40702  primary bilateral, one of two stages
40720  secondary, by recreation of defect and reclosure
        (For bilateral procedure, use modifier -50)
40761  with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle

OTHER PROCEDURES

40799  Unlisted procedure, lips

VESTIBULE OF MOUTH

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

INCISION

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

EXCISION, DESTRUCTION

40808  Biopsy, vestibule of mouth
40810  Excision of lesion of mucosa and submucosa vestibule of mouth; without repair
40812  with simple repair
40814  with complex repair
40816  complex with excision of underlying muscle
40818  Excision of mucosa of vestibule of mouth as donor graft
40819  Excision of frenum, labial or buccal (frenulectomy, 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
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>40831</td>
<td>over 2.5 cm or complex</td>
</tr>
<tr>
<td>40840</td>
<td>Vestibuloplasty; anterior</td>
</tr>
<tr>
<td>40842</td>
<td>posterior, unilateral</td>
</tr>
<tr>
<td>40843</td>
<td>posterior, bilateral</td>
</tr>
<tr>
<td>40844</td>
<td>entire arch</td>
</tr>
<tr>
<td>40845</td>
<td>complex (including ridge extension, muscle repositioning)</td>
</tr>
</tbody>
</table>

**OTHER PROCEDURES**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>40899</td>
<td>Unlisted procedure, vestibule of mouth</td>
</tr>
</tbody>
</table>

**TONGUE AND FLOOR OF MOUTH**

**INCISION**

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

**EXCISION**

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

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

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

DENTOALVEOLAR STRUCTURES

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

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

OTHER PROCEDURES
41870  Periodontal mucosal grafting
41872  Gingivoplasty, each quadrant (specify)
41874  Alveoloplasty each quadrant (specify)
41899  Unlisted procedure, dentoalveolar structures
Physician - Procedure Codes, Section 5 - Surgery

PALATE AND UVULA

INCISION

42000 Drainage of abscess of palate, uvula

EXCISION, DESTRUCTION

42100 Biopsy of palate, uvula
42104 Excision, lesion of palate, uvula; without closure
42106 with simple primary closure
42107 with local flap closure
42120 Resection of palate or extensive resection of lesion
42140 Uvulectomy, excision of uvula
42145 Palatopharyngoplasty eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
42160 Destruction of lesion, palate or uvula (thermal, cryo or chemical)

REPAIR

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

OTHER PROCEDURES

42299 Unlisted procedure, palate, uvula

SALIVARY GLANDS AND DUCTS

INCISION

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

EXCISION
42400 Biopsy of salivary gland; needle
42405 incisional
42408 Excision of sublingual salivary cyst (ranula)
42409 Marsupialization of sublingual salivary cyst (ranula)
42410 Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection
42415 lateral lobe, with dissection and preservation of facial nerve
42420 total, with dissection and preservation of facial nerve
42425 total, en bloc removal with sacrifice of facial nerve
42426 total, with unilateral radical neck dissection
42440 Excision of submandibular (submaxillary) gland
42450 Excision of sublingual gland

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

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

PHARYNX, ADENOIDS, AND TONSILS

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

EXCISION, DESTRUCTION
42800 Biopsy; oropharynx
42804 nasopharynx, visible lesion, simple
42806 nasopharynx, survey for unknown primary lesion
42808 Excision or destruction of lesion of pharynx, any method
42809 Removal of foreign body from pharynx
42810 Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues
42815 Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>42820</td>
<td>Tonsillectomy and adenoidectomy; under age 12</td>
</tr>
<tr>
<td>42821</td>
<td>age 12 or over</td>
</tr>
<tr>
<td>42825</td>
<td>Tonsillectomy, primary or secondary; under age 12</td>
</tr>
<tr>
<td>42826</td>
<td>age 12 or over</td>
</tr>
<tr>
<td>42830</td>
<td>Adenoidectomy, primary; under age 12</td>
</tr>
<tr>
<td>42831</td>
<td>age 12 or over</td>
</tr>
<tr>
<td>42835</td>
<td>Adenoidectomy, secondary; under age 12</td>
</tr>
<tr>
<td>42836</td>
<td>age 12 or over</td>
</tr>
<tr>
<td>42842</td>
<td>Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure</td>
</tr>
<tr>
<td>42844</td>
<td>closure with local flap (e.g., tongue, buccal)</td>
</tr>
<tr>
<td>42845</td>
<td>closure with other flap</td>
</tr>
<tr>
<td>42850</td>
<td>Excision of tonsil tags</td>
</tr>
<tr>
<td>42870</td>
<td>Excision or destruction lingual tonsil, any method (separate procedure)</td>
</tr>
<tr>
<td>42890</td>
<td>Limited pharyngectomy</td>
</tr>
<tr>
<td>42892</td>
<td>Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls</td>
</tr>
<tr>
<td>42894</td>
<td>Resection of pharyngeal wall requiring closure with myocutaneous or fasciocutaneous flap or free muscle, skin, or fascial flap with microvascular anastomosis</td>
</tr>
<tr>
<td>42900</td>
<td>Suture pharynx for wound or injury</td>
</tr>
<tr>
<td>42950</td>
<td>Pharyngoplasty (plastic or reconstructive operation on pharynx)</td>
</tr>
<tr>
<td>42953</td>
<td>Pharyngoesophageal repair</td>
</tr>
<tr>
<td>42955</td>
<td>Pharyngostomy (fistulization of pharynx, external for feeding)</td>
</tr>
<tr>
<td>42960</td>
<td>Control oropharyngeal hemorrhage primary or secondary (e.g., post-tonsillectomy); simple</td>
</tr>
<tr>
<td>42961</td>
<td>complicated, requiring hospitalization</td>
</tr>
<tr>
<td>42962</td>
<td>with secondary surgical intervention</td>
</tr>
<tr>
<td>42970</td>
<td>Control of nasopharyngeal hemorrhage, primary or secondary (e.g., postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cautery</td>
</tr>
<tr>
<td>42971</td>
<td>complicated, requiring hospitalization</td>
</tr>
<tr>
<td>42972</td>
<td>with secondary surgical intervention</td>
</tr>
<tr>
<td>42999</td>
<td>Unlisted procedure, pharynx, adenoids, or tonsils</td>
</tr>
<tr>
<td>43020</td>
<td>Esophagotomy, cervical approach, with removal of foreign body</td>
</tr>
<tr>
<td>43030</td>
<td>Cricopharyngeal myotomy</td>
</tr>
<tr>
<td>43045</td>
<td>Esophagotomy, thoracic approach, with removal of foreign body</td>
</tr>
<tr>
<td>43100</td>
<td>Excision of lesion, esophagus, with primary repair; cervical approach</td>
</tr>
</tbody>
</table>
43101  thoracic or abdominal approach
43107  Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)
43108  with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)
43112  Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (ie, McKeown esophagectomy or tricisional esophagectomy)
43113  with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43116  Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction
43117  Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagagastrostomy, with or without pyloroplasty (Ivor Lewis)
43118  with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43121  Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagagastrostomy, with or without pyloroplasty
43122  Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagagastrostomy, with or without pyloroplasty
43123  with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43124  Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy
43130  Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach
43135  thoracic approach

**ENDOSCOPY**

43180  Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker’s diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed
(Do not report 43180 in conjunction with 69990)
43191  Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)
43192  with directed submucosal injection(s), any substance
43193  with biopsy, single or multiple
43194  with removal of foreign body(s)
43195  with balloon dilation (less than 30 mm diameter)
43196  with insertion of guide wire followed by dilation over guide wire
43197  Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43198  with biopsy, single or multiple
43200 Esophagoscopy, flexible; transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43201 with directed submucosal injection(s), any substance
43202 with biopsy, single or multiple
43204 with injection sclerosis of esophageal varices
43205 with band ligation of esophageal varices
43206 with optical endomicroscopy
43215 with removal of foreign body(s)
43216 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
43217 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43211 with endoscopic mucosal resection
43212 with placement of endoscopic stent (includes pre and post-dilation and guide wire passage, when performed)
43220 with transendoscopic balloon dilation (less than 30 mm diameter)
43213 with dilation of esophagus by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)
43214 with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)
43226 with insertion of guide wire followed by passage of dilator(s) over guide wire
43227 with control of bleeding, any method
43229 with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre and post-dilation and guide wire passage, when performed)
43231 with endoscopic ultrasound examination
(Do not report 43231 in conjunction with 76975)
43232 with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)
43235 Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43236 with directed submucosal injection(s), any substance
43237 with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum and adjacent structures
43238 with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)
43239 with biopsy, single or multiple
43240 with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed and endoscopic ultrasound, when performed)
43241 with insertion of intraluminal tube or catheter
43242 with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)
43243 with injection sclerosis of esophageal gastric varices
43244 with band ligation of esophageal gastric varices
43245 with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)  
(Do not report 43245 in conjunction with 43256)
43246 with directed placement of percutaneous gastrostomy tube
43247 with removal of foreign body(s)
43248 with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire
43249 with transendoscopically balloon dilation of esophagus (less than 30 mm diameter)
43233 with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)
43250 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
43251 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43252 with optical endomicroscopy
43253 with transendoscopically ultrasound-guided transmural injection or diagnostic or therapeutic substances(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)
43254 with endoscopic mucosal resection
43255 with control of bleeding, any method
43266 with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
43257 with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease
43270 with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
43259 with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis
43210 with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed
43260 Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43261 with biopsy, single or multiple
43262 with sphincterotomy/papillotomy
43263 with pressure measurement of sphincter of Oddi
43264 with removal of calculi/debris from biliary pancreatic duct(s)
43265 with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)
43273 Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s)  
(List separately in addition to code(s) for primary procedure)
43274 with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent
43275 with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)
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43276  with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged

43277  with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty) including sphincterotomy, when performed, each duct

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

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

43279 Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed
(Do not report 43279 in conjunction with 43280)

43280 Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)
(Do not report 43280 in conjunction with 43279)

43281 Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh

43282  with implantation of mesh
(Do not report 43281, 43282 in conjunction with 43280, 43450, 43453, 43456, 43458, 49568)

43283 Laparoscopy, surgical, esophageal lengthening procedure (eg, Collins gastroplasty or wedge gastroplasty)
(List separately in addition to primary procedure)
(Use 43283 in conjunction with 43280, 43281, 43282)

43286 Esophagectomy, total or near total, with laparoscopic mobilization of the abdominal and mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure, if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, laparoscopic transhiatal esophagectomy)

43287 Esophagectomy, distal two-thirds, with laparoscopic mobilization of the abdominal and lower mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with separate thoracoscopic mobilization of the middle and upper mediastinal esophagus and thoracic esophagogastrostomy (ie, laparoscopic thoracoscopic esophagectomy, Ivor Lewis esophagectomy)

43288 Esophagectomy, total or near total, with thoracoscopic mobilization of the upper, middle and lower mediastinal esophagus, with separate laparoscopic proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, thorascopic, laparoscopic and cervical incision esophagectomy, McKeown esophagectomy, tri-incisional esophagectomy)

43289 Unlisted laparoscopy procedure, esophagus

**REPAIR**

43300 Esophagoplasty, (plastic repair or reconstruction), cervical approach; without repair of tracheoesophageal fistula

43305 with repair of tracheoesophageal fistula
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43310</td>
<td>Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula</td>
</tr>
<tr>
<td>43312</td>
<td>with repair of tracheoesophageal fistula</td>
</tr>
<tr>
<td>43313</td>
<td>Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach, without repair of congenital tracheoesophageal fistula</td>
</tr>
<tr>
<td>43314</td>
<td>with repair of congenital tracheoesophageal fistula</td>
</tr>
<tr>
<td></td>
<td>(Do not report modifier –63 in conjunction with 43313, 43314)</td>
</tr>
<tr>
<td>43320</td>
<td>Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach</td>
</tr>
<tr>
<td>43325</td>
<td>Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)</td>
</tr>
<tr>
<td>43327</td>
<td>Esophagogastric fundoplasty partial or complete; laparotomy</td>
</tr>
<tr>
<td>43328</td>
<td>thoracotomy</td>
</tr>
<tr>
<td>43330</td>
<td>Esophagomyotomy (Heller type); abdominal approach</td>
</tr>
<tr>
<td>43331</td>
<td>thoracic approach</td>
</tr>
<tr>
<td>43332</td>
<td>Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis</td>
</tr>
<tr>
<td>43333</td>
<td>with implantation of mesh or other prosthesis</td>
</tr>
<tr>
<td>43334</td>
<td>Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis</td>
</tr>
<tr>
<td>43335</td>
<td>with implantation of mesh or other prosthesis</td>
</tr>
<tr>
<td>43336</td>
<td>Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis</td>
</tr>
<tr>
<td>43337</td>
<td>with implantation of mesh or other prosthesis</td>
</tr>
<tr>
<td>43338</td>
<td>Esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to primary procedure) (Use 43338 in conjunction with 43280, 43327-43337)</td>
</tr>
<tr>
<td>43340</td>
<td>Esophagojejunostomy (without total gastrectomy); abdominal approach</td>
</tr>
<tr>
<td>43341</td>
<td>thoracic approach</td>
</tr>
<tr>
<td>43351</td>
<td>Esophagostomy, fistulization of esophagus, external; thoracic approach</td>
</tr>
<tr>
<td>43352</td>
<td>cervical approach</td>
</tr>
<tr>
<td>43360</td>
<td>Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty</td>
</tr>
<tr>
<td>43361</td>
<td>with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)</td>
</tr>
<tr>
<td>43400</td>
<td>Ligation, direct, esophageal varices</td>
</tr>
<tr>
<td>43401</td>
<td>Transection of esophagus with repair, for esophageal varices</td>
</tr>
<tr>
<td>43405</td>
<td>Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation</td>
</tr>
<tr>
<td>43410</td>
<td>Suture of esophageal wound or injury; cervical approach</td>
</tr>
<tr>
<td>43415</td>
<td>transthoracic or transabdominal approach</td>
</tr>
<tr>
<td>43420</td>
<td>Closure of esophagostomy or fistula; cervical approach</td>
</tr>
<tr>
<td>43425</td>
<td>transthoracic or transabdominal approach</td>
</tr>
</tbody>
</table>

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

OTHER PROCEDURES

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

STOMACH

INCISION

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

EXCISION

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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

43644  Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
       (Do not report 43644 in conjunction with 43846, 49320)
43645     with gastric bypass and small intestine reconstruction to limit absorption
(Do not report 43645 in conjunction with 49320, 43847)

43647 Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648 revision or removal of gastric neurostimulator electrodes, antrum
43651 Laparoscopy, surgical; transection of vagus nerves, truncal
43652 transection of vagus nerves, selective or highly selective
43653 gastrostomy, without construction of gastric tube (e.g., Stamm procedure) (separate procedure)
43659 Unlisted laparoscopy procedure, stomach

INTRODUCTION

43752 Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report) (Do not report 43752 in conjunction with critical care codes 99291-99292, neonatal critical care codes 99295-99296, pediatric critical care codes 99293-99294 or low birth weight intensive care service codes 99298-99299)
43753 Gastric intubation and aspiration(s) therapeutic, necessitating physician's skill (e.g., for gastrointestinal hemorrhage), including lavage if performed
43754 Gastric intubation and aspiration, diagnostic; single specimen (e.g., acid analysis)
43755 collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (e.g., histamine, insulin, pentagastrin, calcium, secretin), includes drug administration
43756 Duodenal intubation and aspiration, diagnostic, includes image guidance; single specimen (e.g., bile study for crystals or afferent loop culture)
43757 collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration
43761 Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition (Do not report 43761 in conjunction with 44500, 49446)
43762 Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract
43763 requiring revision of gastrostomy tract

BARIATRIC SURGERY

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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

Typical postoperative follow-up care after gastric restriction using the adjustable gastric band technique includes subsequent band adjustment(s) through the postoperative period for the typical patient. Band adjustment refers to changing the gastric band component diameter by injection or aspiration of fluid through the subcutaneous port component.
43770 Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
   (For individual component placement, report 43770 with modifier 52)
43771 revision of adjustable gastric restrictive device component only
43772 removal of adjustable gastric restrictive component only
43773 removal and replacement of adjustable gastric restrictive device component only
   (Do not report 43773 in conjunction with 43772)
43774 removal of adjustable gastric restrictive device and subcutaneous port components
43775 longitudinal gastrectomy (ie, sleeve gastrectomy)

OTHER PROCEDURES

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

43999  Unlisted procedure, stomach

INTESTINES (EXCEPT RECTUM)

INCISION

44005  Enterolysis (freeing of intestinal adhesion) (separate procedure)
(Do not report 44005 in addition to 45136)

44010  Duodenotomy, for exploration, biopsy(s), or foreign body removal

44015  Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method
(List separately in addition to primary procedure)

44020  Enterotomy, small bowel, other than duodenum; for exploration, biopsy(s), or foreign body
removal

44021   for decompression (eg, Baker tube)

44025  Colotomy, for exploration, biopsy(s), or foreign body removal

44050  Reduction of volvulus, intussusception, internal hernia, by laparotomy

44055  Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg,
Ladd procedure)
(Do not report modifier 63 in conjunction with 44055)

EXCISION

44100  Biopsy of intestine by capsule, tube, peroral (one or more specimens)

44110  Excision of one or more lesions of small or large intestine not requiring anastomosis,
exteriorization, or fistulization; single enterotomy

44111   multiple enterotomies

44120  Enterectomy, resection of small intestine; single resection and anastomosis
(Do not report 44120 in addition to 45136)

44121   each additional resection and anastomosis
(List separately in addition to primary procedure)
(Use 44121 in conjunction with 44120)

44125   with enterostomy

44126  Enterectomy, resection of small intestine for congenital atresia, single resection and
anastomosis of proximal segment of intestine, without tapering

44127   with tapering

44128   each additional resection and anastomosis
(List separately in addition to primary procedure)
(Use 44128 in conjunction with 44126, 44127)
(Do not report modifier 63 in conjunction with 44126, 44127, 44128)

44130  Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy
(separate procedure)

44133  Donor enterectomy, open, (with preparation and maintenance of allograft); partial, from
living donor

44135  Intestinal allotransplantation; from cadaver donor

44136   from living donor
44137  Removal of transplanted intestinal allograft, complete
44139  Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy
   (List separately in addition to primary procedure)
   (Use 44139 only for codes 44140-44147)

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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

INCISION

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

ENTEROSTOMY-EXTERNAL FISTULIZATION OF INTESTINES

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

EXCISION

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

44207  colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)

44208  colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy

44210  colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy

44211  colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed

44212  colectomy, total, abdominal, with proctectomy, with ileostomy

44213 Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy
   (List separately in addition to primary procedure)
   (Use 44213 in conjunction with 44204-44208)

REPAIR

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

OTHER PROCEDURES

44238 Unlisted laparoscopy procedure, intestine (except rectum)

ENTEROSTOMY - EXTERNAL FISTULIZATION OF INTESTINES

44300 Placement, enterostomy, or cecostomy, tube open (eg, for feeding or decompression) (separate procedure)

44310 Ileostomy or jejunostomy, non-tube
   (For laparoscopic procedure, use 44187)
   (Do not report 44310 in conjunction with 44144, 44150-44151, 44155, 44156, 45113, 45119, 45136)

44312 Revision of ileostomy; simple (release of superficial scar) (separate procedure)

44314 complicated (reconstruction in depth) (separate procedure)

44316 Continent ileostomy (Kock procedure) (separate procedure)

44320 Colostomy or skin level cecostomy;
   (Do not report 44320 in conjunction with 44141, 44144, 44146, 44605, 44110, 45119, 45126, 45563, 45805, 45825, 50810, 51597, 57307, or 58240)
   with multiple biopsies (eg, for congenital megacolon) (separate procedure)

44340 Revision of colostomy; simple (release of superficial scar) (separate procedure)

44345 complicated (reconstruction in depth) (separate procedure)

44346 with repair of paracolostomy hernia (separate procedure)

ENDOSCOPY, SMALL INTESTINE AND STOMAL

Surgical endoscopy always includes diagnostic endoscopy.
44360  Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

44361  with biopsy, single or multiple
44363  with removal of foreign body(s)
44364  with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44365  with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
44366  with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44369  with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44370  with transendoscopic stent placement (includes predilation)
44372  with placement of percutaneous jejunostomy tube
44373  with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube
44376  Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

44377  with biopsy, single or multiple
44378  with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44379  with transendoscopic stent placement (includes predilation)
44380  Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

44382  with biopsy, single or multiple
44381  with transendoscopic balloon dilation
   (Do not report 44381 in conjunction with 44380,44384)
44384  with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
44385  Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44386  with biopsy, single or multiple
44388  Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

44389  with biopsy, single or multiple
44390  with removal of foreign body(s)
44391  with control of bleeding, any method
44392  with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
44401  with ablation of tumor(s), polyp(s), or other lesions(s), (includes pre- and post-dilation and guide wire passage, when performed)
44394  with removal of tumor(s), polyp(s), or other lesion(s) by snare techniques
44402  with endoscopic stent placement (including pre- and post-dilaton and guide wire passage, when performed)
44403  with endoscopic mucosal resection
44404  with directed submucosal injection(s), any substance
44405  with transendoscopic balloon dilation
44406  with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44407  with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44408  with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed

INTRODUCTION

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

REPAIR

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

OTHER PROCEDURES

44700  Exclusion of small intestine from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum)
44701  Intraoperative colonic lavage
(List separately in addition to primary procedure)
(Use 44701 in conjunction with 44140, 44145, 44150, or 44604 as appropriate)
(Do not report 44701 in conjunction with 44300, 44950-44960)
44799  Unlisted procedure, small intestine
MECKEL’S DIVERTICULUM AND THE MESENTERY

EXCISION

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

SUTURE

44850  Suture of mesentery (separate procedure)

OTHER PROCEDURES

44899  Unlisted procedure, Meckel's diverticulum and the mesentery

APPENDIX

INCISION

44900  Incision and drainage of appendiceal abscess; open

EXCISION

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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

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

RECTUM

INCISION

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

EXCISION

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

**DESTRUCTION**

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

**ENDOSCOPY**

**DEFINITIONS:**

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

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

**COLONOSCOPY**- is the examination of the entire colon, from the rectum to the cecum, and may include the examination of the terminal ileum.
(Surgical endoscopy always includes diagnostic endoscopy)

45300 Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45303 with dilation, (eg, balloon, guide wire, bougie)
45305 with biopsy, single or multiple
45307 with removal of foreign body
45308 with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
45309 with removal of single tumor, polyp, or other lesion by snare technique
45315 with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
45317 with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45320 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (eg, laser)
45321 with decompression of volvulus
45327 with transendoscopic stent placement (includes predilation)
45330 Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45331 with biopsy, single or multiple
45332 with removal of foreign body(s)
45333 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45334 with control of bleeding, any method
45335 with directed submucosal injection(s), any substance
45337 with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube when performed
45338 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45346 with ablation of tumor(s), polyp(s), or other lesions(s), (includes pre- and post-dilation and guide wire passage, when performed)
45340 with transendoscopic balloon dilation
45341 with endoscopic ultrasound examination
45342 with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45347 with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
45349 with endoscopic mucosal resection
45350 with band ligation(s) (eg, hemorrhoids)
45378 Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45379 with removal of foreign body(s)
45380 with biopsy, single or multiple
45381 with directed submucosal injection(s), any substance
45382  with control of bleeding, any method
45388  with ablation of tumor(s), polyp(s), or other lesions(s), (includes pre- and post-dilation and guide wire passage, when performed)
45384  with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45385  with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386  with transendoscopic balloon dilation
45389  with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
45391  with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse or ascending colon and cecum, and adjacent structures
45392  with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45390  with endoscopic mucosal resection
45393  with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
45398  with band ligation(s) (eg, hemorrhoids)

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

**EXCISION**

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

**REPAIR**

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

**REPAIR**

45500  Proctoplasty; for stenosis
45505  for prolapse of mucous membrane
45520  Perirectal injection of sclerosing solution for prolapse
45540  Proctopexy (eg, for prolapse); abdominal approach
45541  perineal approach
45550  with sigmoid resection, abdominal approach
45560  Repair of rectocele (separate procedure)
45562  Exploration, repair, and presacral drainage for rectal injury;
45563  with colostomy
45800 Closure of rectovesical fistula;
45805 with colostomy
45820 Closure of rectourethral fistula;
45825 with colostomy

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

OTHER PROCEDURES
45399 Unlisted procedure, colon
45999 Unlisted procedure, rectum

ANUS

INCISION
46020 Placement of seton
(Do not report 46020 in addition to 46060, 46280, 46600)
46030 Removal of anal seton, other marker
46040 Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)
46045 Incision and drainage of intramural, intramuscular or submucosal abscess, transanal, under anesthesia
46050 Incision and drainage, perianal abscess, superficial
(See also 45020, 46060)
46060 Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submucosal, with or without placement of seton
(Do not report 46060 in addition to 46020)
(See also 45020)
46070 Incision, anal septum (infant)
(Do not report modifier –63 in conjunction with 46070)
46080 Sphincterotomy, anal, division of sphincter (separate procedure)
46083 Incision of thrombosed hemorrhoid, external

EXCISION
46200 Fissurectomy, including sphincterotomy, when performed
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, external and internal, simple column/group;
46257 with fissurectomy
46258 with fistulectomy, including fissurectomy, when performed
46260 Hemorrhoidectomy, internal and external, 2 or more columns/groups;
46261 with fissurectomy
46262 with fistulectomy, including fissurectomy, when performed
46270 Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous
46275 intersphincteric
46280 transsphincteric, suprasphincteric, extrasphincteric or multiple, including placement of seton, when performed
   (Do not report 46280 in conjunction with 46020)
46285 second stage
46288 Closure of anal fistula with rectal advancement flap
46320 Excision of thrombosed hemorrhoid, external

**INTRODUCTION**

46500 Injection of sclerosing solution, hemorrhoids
46505 Chemodenervation of internal anal sphincter

**ENDOSCOPY**

(Surgical endoscopy always includes diagnostic endoscopy)

46600 Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
46601 diagnostic, with high resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed
46604 with dilation, (eg, balloon, guide wire, bougie)
46606 with biopsy, single or multiple
46607 with high resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple
46608 with removal of foreign body
46610 with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
46611 with removal of single tumor, polyp, or other lesion by snare technique
46612 with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
46614 with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
46615 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

**REPAIR**

46700 Anoplasty, plastic operation for stricture; adult
46705 infant
46706  Repair of anal fistula with fibrin glue
46707  Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])
46710  Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach
46712  combined transperineal and transabdominal approach
46715  Repair of low imperforate anus; with anoperineal fistula (cut-back procedure)
46716  with transposition of anoperineal or anovestibular fistula
46730  Repair of high imperforate anus without fistula; perineal or sacroperineal approach
46735  combined transabdominal and sacroperineal approaches
46740  Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach
46742  combined transabdominal and sacroperineal approaches
46744  Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty; sacroperineal approach
46746  Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach
46748  with vaginal lengthening by intestinal graft and pedicle flaps
46750  Sphincteroplasty, anal, for incontinence or prolapse; adult
46751  child
46753  Graft (Thiersch operation) for rectal incontinence and/or prolapse
46754  Removal of Thiersch wire or suture, anal canal
46760  Sphincteroplasty, anal, for incontinence, adult; muscle transplant
46761  levator muscle imbrication (Park posterior anal repair)

DESTRUCTION

46900  Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
46910  electrodesiccation
46916  cryosurgery
46917  laser surgery
46922  surgical excision
46924  Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
46930  Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)
46940  Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); initial
46942  subsequent

SUTURE

46945  Ligation of internal hemorrhoids; single procedure
46946  multiple procedures
46947  Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling
OTHER PROCEDURES

46999  Unlisted procedure, anus

LIVER

INCISION

47000  Biopsy of liver, needle; percutaneous
47001  when done for indicated purpose at time of other major procedure
        (List separately in addition to primary procedure)
47010  Hepatotomy; for open drainage of abscess or cyst, one or two stages
47015  Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or
        echinococcal) cyst(s) or abscess(es)

EXCISION

47100  Biopsy of liver, wedge
47120  Hepatectomy, resection of liver; partial lobectomy
47122    trisegmentectomy
47125    total left lobectomy
47130    total right lobectomy

LIVER TRANSPLANTATION

47135  Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age

REPAIR

47300  Marsupialization of cyst or abscess of liver
47350  Management of liver hemorrhage; simple suture of liver wound or injury
47360    complex, suture of liver wound or injury, with or without hepatic artery ligation
47361    exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or
        without packing of liver
47362    re-exploration of hepatic wound for removal of packing

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

47370  Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency
47371    cryosurgical
47379  Unlisted laparoscopic procedure, liver

OTHER PROCEDURES

47380  Ablation, open, of 1 or more liver tumor(s); radiofrequency
47381    cryosurgical
47382 Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency
47383 Ablation, 1 or more liver tumor(s), percutaneous, cryoablation
47399 Unlisted procedure, liver

**BILIARY TRACT**

**INCISION**

47400 Hepaticotomy or hepaticostomy with exploration, drainage, or removal of calculus
47420 Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; without transduodenal sphincterotomy or sphincteroplasty
47425 with transduodenal sphincterotomy or sphincteroplasty
47460 Transduodenal sphincterotomy or sphincteroplasty, with or without transduodenal extraction of calculus (separate procedure)
47480 Cholecystotomy or cholecystostomy, open with exploration, drainage, or removal of calculus (separate procedure)

**INTRODUCTION**

47490 Cholecystotomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation
47531 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access
47532 new access (eg, percutaneous transhepatic cholangiogram)
(Do not report 47531, 47532 in conjunction with 47490, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540, 47541 for procedures performed though the same percutaneous access)
(For intraoperative cholangiography, see 74300, 74301)
47533 Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external
47534 internal-external
47535 Conversion of external biliary drainage catheter to internal-external biliary catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation
47536 Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation
(Do not report 47536 in conjunction with 47538 for the same access)
(47536 includes exchange of one catheter. For exchange of additional catheter[s]during the same session, report 47536 with modifier 59 for each additional exchange)
47537 Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed,
imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation

47538 Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation, existing access

47539 new access, without placement of separate biliary drainage catheter

47540 new access, with placement of separate biliary drainage catheter (eg, external or internal-external)

47541 Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation, new access

47542 Balloon dilation of biliary duct(s) or of ampulla ( sphincteroplasty), percutaneous, including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, each duct (List separately in addition to code for primary procedure)

(Use 47542 in conjunction with 47531, 47532, 47533, 47534, 47535, 47536, 47541)
(Do not report 47542 in conjunction with 43262, 43277, 47538, 47539, 47540, 47555, 47556)
(Do not report 47542 in conjunction with 47544 if a balloon is used for removal of calculi, debris, and/or sludge rather than for dilation)
(For percutaneous balloon dilation of multiple ducts during the same session, report an additional dilation once with 47542 and modifier 59, regardless of the number of additional ducts dilated)
(For endoscopic balloon dilation, see 43277, 47555, 47556)

47543 Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple

(List separately in addition to code for primary procedure)
(Use 47543 in conjunction with 47531, 47532, 47533, 47534, 47535, 47536, 47537, 47540)
(Report 47543 once per session)
(For endoscopic brushings, see 43260, 47552)
(For endoscopic biopsy, see 43261, 47553)

47544 Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

ENDOSCOPY

Surgical endoscopy always includes diagnostic endoscopy.

47550 Biliary endoscopy, intraoperative (choledochoscopy)
(List separately in addition to primary procedure)
47552  Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with collection of specimen(s) by brushing and/or washing, when performed (separate procedure)
47553       with biopsy, single or multiple
47554       with removal of calculus/calculi
47555       with dilation of biliary duct stricture(s) without stent
47556       with dilation of biliary duct stricture(s) with stent

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy

47562  Laparoscopy; surgical; cholecystectomy
47563       cholecystectomy with cholangiography
47564       cholecystectomy with exploration of common duct
47570       cholecystoenterostomy
47579  Unlisted laparoscopy procedure, biliary tract

EXCISION

47600  Cholecystectomy;
47605       with cholangiography
47610  Cholecystectomy with exploration of common duct;
47612       with choledochoenterostomy
47620       with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography
47700  Exploration for congenital atresia of bile ducts, without repair, with or without liver biopsy, with or without cholangiography
47701  Portoenterostomy (eg, Kasai procedure)
 (Do not report modifier 63 in conjunction with 47700, 47701)
47711  Excision of bile duct tumor, with or without primary repair of bile duct; extrahepatic
47712       intraphepatic
47715  Excision of choledochal cyst

REPAIR

47720  Cholecystoenterostomy; direct
47721       with gastroenterostomy
47740       Roux-en-Y
47741       Roux-en-Y with gastroenterostomy
47760  Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract
47765  Anastomosis, of intrahepatic ducts and gastrointestinal tract
47780  Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract
47785  Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal tract
47800  Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis
47801  Placement of choledochal stent
47802  U-tube hepaticoenterostomy
47900  Suture of extrahepatic biliary duct for pre-existing injury (separate procedure)
OTHER PROCEDURES

47999 Unlisted procedure, biliary tract

PANCREAS

INCISION

48000 Placement of drains, peripancreatic, for acute pancreatitis;
48001 with cholecystostomy, gastrostomy, and jejunostomy
48020 Removal of pancreatic calculus

EXCISION

48100 Biopsy of pancreas, open, (eg, fine needle aspiration, needle core biopsy, wedge biopsy)
48102 Biopsy of pancreas, percutaneous needle
48105 Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis
48120 Excision of lesion of pancreas (eg, cyst, adenoma)
48140 Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy
48145 with pancreaticojejunostomy
48146 Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)
48148 Excision of ampulla of Vater
48150 Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, cholecystoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreaticojejunostomy
48152 without pancreaticojejunostomy
48153 Pancreatectomy, proximal subtotal with near-total duodenectomy, cholecystoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreaticojejunostomy
48154 without pancreaticojejunostomy
48155 Pancreatectomy, total
48160 Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells

INTRODUCTION

48400 Injection procedure for intraoperative pancreatography
(List separately in addition to primary procedure)

REPAIR

48500 Marsupialization of pancreatic cyst
48510 External drainage, pseudocyst of pancreas; open
48520 Internal anastomosis of pancreatic cyst to gastrointestinal tract; direct
48540 Roux-en-Y
48545 Pancreateorrhaphy for injury
48547  Duodenal exclusion with gastrojejunostomy for pancreatic injury
48548  Pancreaticojejunostomy, side-to-side anastomosis (Puestow-type operation)

**PANCREAS TRANSPLANTATION**

48554  Transplantation of pancreatic allograft
48556  Removal of transplanted pancreatic allograft

**OTHER PROCEDURES**

48999  Unlisted procedure, pancreas

**ABDOMEN, PERITONEUM, AND OMENTUM**

**INCISION**

49000  Exploratory laparotomy, exploratory celiotomy with or without biopsy(s)
        (separate procedure)
49002  Reopening of recent laparotomy
49010  Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)
49020  Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess;
        open
49040  Drainage of subdiaphragmatic or subphrenic abscess; open
49060  Drainage of retroperitoneal abscess; open
49062  Drainage of extraperitoneal lymphocele to peritoneal cavity, open
49082  Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance
49083   with imaging guidance
49084  Peritoneal lavage, including imaging guidance, when performed
        (Do not report 49083, 49084 in conjunction with 76942, 77002, 77012, 77021)

**EXCISION, DESTRUCTION**

49180  Biopsy, abdominal or retroperitoneal mass, percutaneous needle
49185  Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including
        contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg,
        ultrasound, fluoroscopy) and radiological supervision and interpretation, when performed
        (For treatment of multiple lesions in a single day requiring separate access, use modifier 59
        for each additional treated lesion)
        (For treatment of multiple interconnected lesions treated through a single access, report
        49185 once)
49203  Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more
        peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm
        diameter or less
49204   largest tumor 5.1-10.0 cm diameter
49205   largest tumor greater than 10.0 cm diameter
        (Do not report 49203-49205 in conjunction with 38770, 38780, 49000, 49010, 49215, 50010,
        50205, 50225, 50236, 50250, 50290, 58900-58960)
49215  Excision of presacral or sacrococcygeal tumor
(Do not report modifier 63 in conjunction with 49215)

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)

49250 Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)
49255 Omentectomy, epiploectomy, resection of omentum (separate procedure)

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

49320 Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
49321 Laparoscopy, surgical; with biopsy (single or multiple)
49322  with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)
49323  with drainage of lymphocele to peritoneal cavity
49324  with insertion of tunneled intraperitoneal catheter
49325  with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed
49326  with omentopexy (omentum tacking procedure)
(List separately in addition to primary procedure)
(Use 49326 in conjunction with 49324, 49325)
49327  with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple
(List separately in addition to primary procedure)
(Use 49327 in conjunction with laparoscopic abdominal, pelvic, or retroperitoneal procedure[s] performed concurrently)

49329 Unlisted laparoscopy procedure, abdomen, peritoneum and omentum

**INTRODUCTION, REVISION AND/OR REMOVAL**

49400 Injection of air or contrast into peritoneal cavity (separate procedure)
49402 Removal of peritoneal foreign body from peritoneal cavity
49405 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous
49406   peritoneal or retroperitoneal, percutaneous
49407   peritoneal or retroperitoneal, transvaginal or transrectal
49411 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple
49412 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple
(List separately in addition to primary procedure)
(Use 49412 in conjunction with open abdominal, pelvic, or retroperitoneal procedure[s] performed concurrently)
49418  Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous

49419  Insertion of tunneled intraperitoneal catheter, with subcutaneous port (ie, totally implantable)

49421  Insertion of tunneled intraperitoneal catheter for dialysis, open

49422  Removal of tunneled intraperitoneal catheter

49423  Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)

49424  Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure)

49425  Insertion of peritoneal-venous shunt

49426  Revision of peritoneal-venous shunt

49427  Injection procedure (eg, contrast media) for evaluation of previously placed peritoneal-venous shunt

49428  Ligation of peritoneal-venous shunt

49429  Removal of peritoneal-venous shunt

49435  Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site
   (List separately in addition to primary procedure)
   (Use 49435 in conjunction with 49324, 49421)

49436  Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter

INITIAL PLACEMENT

Do not additionally report 43752 for placement of a nasogastric (NG) or orogastric (OG) tube to insufflate the stomach prior to percutaneous gastrointestinal tube placement. NG or OG tube placement is considered part of the procedure in this family of codes.

49440  Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
   (For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, use 49440 in conjunction with 49446)

49441  Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

49442  Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

CONVERSION

49446  Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
   (For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, use 49446 in conjunction with 49440)

REPLACEMENT
If an existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube is removed and a new tube is placed via a separate percutaneous access site, the placement of the new tube is not considered a replacement and would be reported using the appropriate initial placement codes 49440-49442.

49450 Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

49451 Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

49452 Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

MECHANICAL REMOVAL OF OBSTRUCTIVE MATERIAL

49460 Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed, image documentation and report (Do not report 49460 in conjunction with 49450-49452, 49465)

OTHER

49465 Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report (Do not report 49465 in conjunction with 49450-49460)

REPAIR

HERNIoplasty, HERNIORRHaphy, HERNIOtomy

The hernia repair codes in this section are categorized primarily by the type of hernia (inguinal, femoral, incisional, etc.). Some types of hernias are further categorized as "initial" or "recurrent" based on whether or not the hernia has required previous repair(s). Additional variables accounted for by some of the codes include patient age and clinical presentation (reducible vs. incarcerated or strangulated).

With the exception of the incisional hernia repairs (see 49560-49566) the use of mesh or other prosthesis is not separately reported.

(Codes 49491-49651 are unilateral procedures. To report bilateral procedures, report modifier -50 with the appropriate procedure code)

(Do not report modifier -63 in conjunction with 49491, 49492, 49495, 49496, 49600, 49605, 49606, 49610, 49611)

49491 Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks post-conception age, with or without hydrocelectomy; reducible

49492 incarcerated or strangulated
49495  Repair initial inguinal hernia, full term infant younger than 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; reducible
49496  incarcerated or strangulated
49500  Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible
49501  incarcerated or strangulated
49505  Repair initial inguinal hernia, age 5 years or over; reducible
49507  incarcerated or strangulated
49520  Repair recurrent inguinal hernia, any age; reducible
49521  incarcerated or strangulated
49525  Repair inguinal hernia, sliding, any age
49540  Repair lumbar hernia
49550  Repair initial femoral hernia, any age; reducible
49553  incarcerated or strangulated
49555  Repair recurrent femoral hernia; reducible
49557  incarcerated or strangulated
49560  Repair initial incisional or ventral hernia; reducible
49561  incarcerated or strangulated
49565  Repair recurrent incisional or ventral hernia; reducible
49566  incarcerated or strangulated
49568  Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection
(Use separately in addition to code for the incisional or ventral hernia repair)
(Use 49568 in conjunction with 11004-11006, 49560-49566)
49570  Repair epigastric hernia (eg. preperitoneal fat); reducible (separate procedure);
49572  incarcerated or strangulated
49580  Repair umbilical hernia, younger than age 5 years; reducible
49582  incarcerated or strangulated
49585  Repair umbilical hernia, age 5 years or over; reducible
49587  incarcerated or strangulated
49590  Repair spigelian hernia
49600  Repair of small omphalocele, with primary closure
49605  Repair of large omphalocele or gastroschisis; with or without prosthesis
49606  with removal of prosthesis, final reduction and closure, in operating room
49610  Repair of omphalocele (Gross type operation); first stage
49611  second stage

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

49650  Laparoscopy, surgical; repair initial inguinal hernia
49651  repair recurrent inguinal hernia
49652  Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
49653  incarcerated or strangulated
49654  Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible
49655  incarcerated or strangulated
49656  Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible
49657  incarcerated or strangulated
(Do not report 49652-49657 in conjunction with 44180, 49568)
49659  Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy

**SUTURE**

49900  Suture, secondary, of abdominal wall for evisceration or dehiscence

**OTHER PROCEDURES**

49904  Omental flap, extra-abdominal (eg, for reconstruction of sternal and chest wall defects)
(Code 49904 includes harvest and transfer. If a second surgeon harvests the omental flap, then the two surgeons should code 49904 as co-surgeons, using modifier 62)
49905  Omental flap, intra-abdominal
(List separately in addition to primary procedure)
(Do not report 49905 in conjunction with 47700)
49906  Free omental flap with microvascular anastomosis
49999  Unlisted procedure, abdomen, peritoneum and omentum

**URINARY SYSTEM**

**KIDNEY**

**INCISION**

50010  Renal exploration, not necessitating other specific procedures
50020  Drainage of perirenal or renal abscess; open
50040  Nephrostomy, nephrotomy with drainage
50045  Nephrotomy, with exploration
50060  Nephrolithotomy; removal of calculus
50065  secondary surgical operation for calculus
50070  complicated by congenital kidney abnormality
50075  removal of large staghorn calculus filling renal pelvis and calyces (including anatrophic pyelolithotomy)
50080  Percutaneous nephrostolithotomy or pyelolithotomy, with or without dilation, endoscopy, lithotripsy, stenting or basket extraction; up to 2 cm
50081  over 2 cm
50100  Transection or repositioning of aberrant renal vessels (separate procedure)
50120  Pyelotomy; with exploration
50125  with drainage, pyelostomy
50130  with removal of calculus (pyelolithotomy, pelviolithotomy, including coagulum pyelolithotomy)
50135 complicated (eg, secondary operation, congenital kidney abnormality)

**EXCISION**

50200 Renal biopsy; percutaneous, by trocar or needle
50205 by surgical exposure of kidney
50220 Nephrectomy, including partial ureterectomy, any open approach including rib resection;
50225 complicated because of previous surgery on same kidney
50230 radical, with regional lymphadenectomy and/or vena caval thrombectomy
50234 Nephrectomy with total ureterectomy and bladder cuff; through same incision
50236 through separate incision
50240 Nephrectomy, partial
50250 Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative
    ultrasound guidance and monitoring, if performed
50280 Excision or unroofing of cyst(s) of kidney
50290 Excision of perinephric cyst

**RENAL TRANSPLANTATION**

50320 Donor nephrectomy (including cold preservation); open, from living donor
50340 Recipient nephrectomy (separate procedure)
    (For bilateral procedure, report 50340 with modifier 50)
50360 Renal allotransplantation, implantation of graft; without recipient nephrectomy
50365 with recipient nephrectomy
50370 Removal of transplanted renal allograft
50380 Renal autotransplantation, reimplantation of kidney

**INTRODUCTION**

**RENAL PELVIS CATHETER PROCEDURES**

**INTERNALLY DWELLING**

50382 Removal (via snare/capture) and replacement of internally dwelling ureteral stent via
    percutaneous approach, including radiological supervision and interpretation
50384 Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach,
    including radiological supervision and interpretation

50385 Removal (via snare/capture) and replacement of internally dwelling ureteral stent via
    transurethral approach, without use of cystoscopy, including radiological supervision and
    interpretation
50386 Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach,
    without use of cystoscopy, including radiological supervision and interpretation

**EXTERNALLY ACCESSIBLE**

50387 Removal and replacement of externally accessible transnephric ureteral stent
(eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation

50389  Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent)

OTHER INTRODUCTION PROCEDURES

50390  Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous
50391  Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent)
50436  Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed;
50437   including new access into the renal collecting system
50396  Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter
50430  Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access
50431   existing access
   (Do not report 50430, 50431 in conjunction with 50432, 50433, 50434, 50435, 50693, 50694, 50695, 74425 for the same renal collecting system and/or associated ureter)
50432  Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
50433  Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access
   (Do not report 50433 in conjunction with 50430, 50431, 50432, 50693, 50694, 50695, 74425 for the same renal collecting system and/or associated ureter)
50434  Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via existing nephrostomy tract
   (Do not report 50434 in conjunction with 50430, 50431, 50432, 50693, 50694, 50695, 74425 for the same renal collecting system and/or associated ureter)
50435  Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
   (Do not report 50435 in conjunction with 50430, 50431, 50434, 50693, 74425 for the same renal collecting system and/or associated ureter)

REPAIR

50400  Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple
50405 complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calycoplasty)
50500 Nephorrhaphy, suture of kidney wound or injury
50520 Closure of nephrocutaneous or pyelocutaneous fistula
50525 Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; abdominal approach
50526 thoracic approach
50540 Symphysiotomy for horseshoe kidney with or without pyeloplasty and/or other plastic procedure, unilateral or bilateral (one operation)

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

50541 Laparoscopy, surgical; ablation of renal cysts
50542 ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed
50543 partial nephrectomy
50544 pyeloplasty
50545 radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)
50546 nephrectomy, including partial ureterectomy
50547 donor nephrectomy (including cold preservation), from living donor
50548 nephrectomy with total ureterectomy
50549 Unlisted laparoscopy procedure, renal

**ENDOSCOPY**

50551 Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50553 with ureteral catheterization, with or without dilation of ureter
50555 with biopsy
50557 with fulguration and/or incision, with or without biopsy
50561 with removal of foreign body or calculus
50562 with resection of tumor
50570 Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50572 with ureteral catheterization, with or without dilation of ureter
50574 with biopsy
50575 with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent)
50576 with fulguration and/or incision, with or without biopsy
50580 with removal of foreign body or calculus

(When procedures 50570-50580 provide a significant identifiable service, they may be added to 50045 and 50120)
OTHER PROCEDURES

(Codes 50592, 50593 are unilateral procedures, for bilateral procedures, report with modifier 50)

50590 Lithotripsy, extracorporeal shock wave
50592 Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency
50593 Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy

URETER

INCISION

50600 Ureterotomy with exploration or drainage (separate procedure)
50605 Ureterotomy for insertion of indwelling stent, all types
50606 Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure) (Do not report 50606 in conjunction with 50555, 50574, 50955, 50974, 52007, 74425 for the same renal collection system and/or ureter)
50610 Ureterolithotomy; upper one-third of ureter
50620 middle one-third of ureter
50630 lower one-third of ureter

EXCISION

50650 Ureterectomy, with bladder cuff (separate procedure)
50660 Ureterectomy, total, ectopic ureter, combination abdominal, vaginal and/or perineal approach

INTRODUCTION

50684 Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter
50686 Manometric studies through ureterostomy or indwelling ureteral catheter
50688 Change of ureterostomy tube or externally accessible ureteral stent via ileal conduit
50690 Injection procedure for visualization of ileal conduit and/or ureteropyelography, exclusive of radiologic service
50693 Placement or ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract (Do not report 50693, 50694, 50695 in conjunction with 50430, 50431, 50432, 50433, 50434, 50435, 50684, 74425 for the same renal collecting system and/or associated ureter)
50694 new access, without separate nephrostomy catheter
50695 new access, with separate nephrostomy catheter

REPAIR

50700 Ureteroplasty, plastic operation on ureter (eg, stricture)
50705 Ureteral embolization or occlusion, including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

50706 Balloon dilation, ureteral stricture, including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
(Do not report 50706 in conjunction with 50553, 50572, 50953, 50972, 52341, 52344, 52345, 74485)

50715 Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis

50722 Ureterolysis for ovarian vein syndrome

50725 Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava

50727 Revision of urinary-cutaneous anastomosis (any type urostomy); with repair of fascial defect and hernia

50740 Ureteropyelostomy, anastomosis of ureter and renal pelvis

50750 Ureterocalyceostomy, anastomosis of ureter to renal calyx

50760 Ureteroureterostomy

50770 Transureteroureterostomy, anastomosis of ureter to contralateral ureter

50780 Ureteroneocystostomy; anastomosis of single ureter to bladder

50782 anastomosis of duplicated ureter to bladder

50783 with extensive ureteral tailoring

50785 with vesico-psoas hitch or bladder flap
(Codes 50780-50785 include minor procedures to prevent vesicoureteral reflux)

50800 Ureteroenterostomy, direct anastomosis of ureter to intestine

50810 Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis

50815 Ureterocolon conduit, including intestine anastomosis

50820 Ureterointestinal conduit (ileal bladder), including intestine anastomosis (Bricker operation)

50825 Continent diversion, including intestine anastomosis using any segment of small and/or large bowel (Kock pouch or Camey enterocystoplasty)

50830 Urinary undiversion (e.g., taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroenterostomy with ureteroureterostomy or ureteroneocystostomy)

50840 Replacement of all or part of ureter by intestine segment, including intestine anastomosis

50845 Cutaneous appendico-vesicostomy

50860 Ureterostomy, transplantation of ureter to skin

50900 Ureterorrhaphy, suture of ureter (separate procedure)

50920 Closure of ureterocutaneous fistula

50930 Closure of ureterovisceral fistula (including visceral repair)

50940 Delegation of ureter

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

50945 Laparoscopy, surgical; ureterolithotomy

50947 ureteroneocystostomy with cystoscopy and ureteral stent placement

50948 ureteroneocystostomy without cystoscopy and ureteral stent placement
50949  Unlisted laparoscopic procedure, ureter

**ENDOSCOPY**

50951  Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50953   with ureteral catheterization, with or without dilation of ureter
50955   with biopsy
50957   with fulguration and/or incision, with or without biopsy
50961   with removal of foreign body or calculus
50970  Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50972   with ureteral catheterization, with or without dilation of ureter
50974   with biopsy
50976   with fulguration and/or incision, with or without biopsy
50980   with removal of foreign body or calculus
(When procedures 50970-50980 provide a significant identifiable service, they may be added to 50600)

**BLADDER**

**INCISION**

51020  Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material
51030   with cryosurgical destruction of intravesical lesion
51040  Cystostomy, cystotomy with drainage
51045  Cystotomy, with insertion of ureteral catheter or stent (separate procedure)
51050  Cystolithotomy, cystotomy with removal of calculus, without vesical neck resection
51060  Transvesical ureterolithotomy
51065  Cystotomy, with calculus basket extraction and/or ultrasonic or electrohydraulic fragmentation of ureteral calculus
51080  Drainage of perivesical or prevesical space abscess

**REMOVAL**

51100  Aspiration of bladder; by needle
51101   by trocar or intracatheter
51102   with insertion of suprapubic catheter

**EXCISION**

51500  Excision of urachal cyst or sinus, with or without umbilical hernia repair
51520  Cystotomy; for simple excision of vesical neck (separate procedure)
51525   for excision of bladder diverticulum, single or multiple (separate procedure)
51530   for excision of bladder tumor
51535  Cystotomy for excision, incision, or repair of ureterocele
   (For bilateral procedure, use modifier -50)
51550  Cystectomy, partial; simple
51555  complicated (eg, postradiation, previous surgery, difficult location)
51565  Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)
51570  Cystectomy, complete; (separate procedure)
51575  with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
51580  Cystectomy, complete with ureterosigmoidostomy or ureterocutaneous transplantations;
51585  with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
51590  Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis;
51595  with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
51596  Cystectomy, complete, with continent diversion, any technique, using any segment of small and/or large intestine to construct neobladder
51597  Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof

INTRODUCTION

51600  Injection procedure for cystography or voiding urethrocystography
51605  Injection procedure and placement of chain for contrast and/or chain urethrocystography
51610  Injection procedure for retrograde urethrocystography
51700  Bladder irrigation, simple, lavage and/or instillation
51703  Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)
(Code 51703 is reported only when performed independently. Do not report 51703 when catheter insertion is an inclusive component of another procedure)
51710  Change of cystostomy tube; complicated
51715  Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
51720  Bladder instillation of anticarcinogenic agent (including retention time)

URODYNAMICS

The following section (51725-51792) lists procedures that may be used separately or in many and varied combinations.

All procedures in this section imply that these services are performed by, or are under the direct supervision of, a physician and that all instruments, equipment, fluids, gases, probes, catheters, technician’s fees, medications, gloves, trays, tubing and other sterile supplies be provided by the physician. When the physician only interprets the results and/or operates the equipment, a professional component, modifier 26, should be used to identify physicians’ services.

51725  Simple cystometrogram (CMG) (eg, spinal manometer)
51726  Complex cystometrogram (ie, calibrated electronic equipment);
Physician - Procedure Codes, Section 5 - Surgery

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 bulbocavernous reflex latency time)
51797  Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal)
   (List separately in addition to primary procedure)
   (Use 51797 in conjunction with 51728, 51729)
51798  Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging

REPAIR

51800  Cystoplasty or cystourethroplasty, plastic operation on bladder and/or vesical neck (anterior Y-plasty, vesical fundus resection), any procedure, with or without wedge resection of posterior vesical neck
51820  Cystourethroplasty with unilateral or bilateral ureteroneocystostomy
51840  Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz, Burch); simple
51841   complicated (eg, secondary repair)
51845  Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)
51860  Cystorrhaphy, suture of bladder wound, injury or rupture; simple
51865   complicated
51880  Closure of cystostomy (separate procedure)
51900  Closure of vesicovaginal fistula, abdominal approach
51920  Closure of vesicouterine fistula;
51925   with hysterectomy (See Rule 14)
51940  Closure, exstrophy of bladder
   (See also 54390)
51960  Enterocystoplasty, including intestinal anastomosis
51980  Cutaneous vesicostomy

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

51990  Laparoscopy, surgical; urethral suspension for stress incontinence
51992   sling operation for stress incontinence (eg, fascia or synthetic)
51999  Unlisted laparoscopy procedure, bladder
**ENDOSCOPY - CYSTOSCOPY, URETHROSCOPY, CYSTOURETHROSCOPY**

Endoscopic descriptions are listed so that the main procedure can be identified without having to list all the minor related functions performed at the same time. For example: meatotomy, urethral calibration and/or dilation, urethroscopy, and cystoscopy prior to a transurethral resection of prostate; ureteral catheterization following extraction of ureteral calculus; internal urethrotomy and bladder neck fulguration when performing a cystourethroscopy for the female urethral syndrome.

52000  Cystourethroscopy (separate procedure)
52001  Cystourethroscopy with irrigation and evacuation of multiple obstructing clots  
   (Do not report 52001 in addition to 52000)
52005  Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or 
   ureteropyelography, exclusive of radiologic service;  
   with brush biopsy of ureter and/or renal pelvis
52010  Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, 
   or duct radiography, exclusive of radiologic service

**TRANSURETHRAL SURGERY**

**URETHRA AND BLADDER**

52204  Cystourethroscopy, with biopsy(s)
52214  Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, 
   bladder neck, prostatic fossa, urethra, or periurethral glands
52224  Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of 
   MINOR (less than 0.5 cm) lesion(s), with or without biopsy
52234  Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection 
   of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)
52235  MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52240  LARGE bladder tumor(s)
52250  Cystourethroscopy with insertion of radioactive substance, with or without biopsy or 
   fulguration
52260  Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction 
   (spinal) anesthesia
52265  local anesthesia
52270  Cystourethroscopy, with internal urethrotomy; female
52275  male
52276  Cystourethroscopy, with direct vision internal urethrotomy
52277  Cystourethroscopy, with resection of external sphincter (sphinctorotomy)
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
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52287</td>
<td>Cystourethroscopy, with injection(s) for chemodenervation of the bladder</td>
</tr>
<tr>
<td>52290</td>
<td>Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral</td>
</tr>
<tr>
<td>52300</td>
<td>with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral</td>
</tr>
<tr>
<td>52301</td>
<td>with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral</td>
</tr>
<tr>
<td>52305</td>
<td>with incision or resection of orifice of bladder diverticulum, single or multiple</td>
</tr>
<tr>
<td>52310</td>
<td>Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple</td>
</tr>
<tr>
<td>52315</td>
<td>complicated</td>
</tr>
<tr>
<td>52317</td>
<td>Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)</td>
</tr>
<tr>
<td>52318</td>
<td>complicated or large (over 2.5 cm)</td>
</tr>
</tbody>
</table>

**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 cystourethroscope with ureteroscopy and/or pyeloscopy is included in 52320-52355 and should not be reported separately.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52320</td>
<td>Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus</td>
</tr>
<tr>
<td>52325</td>
<td>with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)</td>
</tr>
<tr>
<td>52327</td>
<td>with subureteric injection of implant material</td>
</tr>
<tr>
<td>52330</td>
<td>with manipulation, without removal of ureteral calculus</td>
</tr>
<tr>
<td>52332</td>
<td>Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)</td>
</tr>
<tr>
<td>52334</td>
<td>Cystourethroscopy, with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde</td>
</tr>
<tr>
<td>52341</td>
<td>Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)</td>
</tr>
<tr>
<td>52342</td>
<td>with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)</td>
</tr>
<tr>
<td>52343</td>
<td>with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)</td>
</tr>
<tr>
<td>52344</td>
<td>Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)</td>
</tr>
<tr>
<td>52345</td>
<td>with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)</td>
</tr>
<tr>
<td>52346</td>
<td>with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)</td>
</tr>
<tr>
<td>52351</td>
<td>Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic</td>
</tr>
</tbody>
</table>

(Do not report 52351 in conjunction with 52341-52346, 52352-52355)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52352</td>
<td>with removal or manipulation of calculus (ureteral catheterization is included)</td>
</tr>
<tr>
<td>52353</td>
<td>with lithotripsy (ureteral catheterization is included)</td>
</tr>
<tr>
<td>52354</td>
<td>with biopsy and/or fulguration of ureteral or renal pelvic lesion</td>
</tr>
<tr>
<td>52355</td>
<td>with resection of ureteral or renal pelvic tumor</td>
</tr>
<tr>
<td>52356</td>
<td>with lithotripsy including insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)</td>
</tr>
</tbody>
</table>

**VESICAL NECK AND PROSTATE**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52400</td>
<td>Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds</td>
</tr>
<tr>
<td>52402</td>
<td>Cystourethroscopy with transurethral resection or incision of ejaculatory ducts</td>
</tr>
<tr>
<td>52441</td>
<td>Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant</td>
</tr>
<tr>
<td>55242</td>
<td>each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>52450</td>
<td>Transurethral incision of prostate</td>
</tr>
<tr>
<td>52500</td>
<td>Transurethral resection of bladder neck (separate procedure)</td>
</tr>
<tr>
<td>52601</td>
<td>Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)</td>
</tr>
<tr>
<td>52630</td>
<td>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)</td>
</tr>
<tr>
<td>52640</td>
<td>of postoperative bladder neck contracture</td>
</tr>
<tr>
<td>52647</td>
<td>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)</td>
</tr>
<tr>
<td>52648</td>
<td>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)</td>
</tr>
<tr>
<td>52649</td>
<td>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)</td>
</tr>
<tr>
<td></td>
<td>(Do not report 52649 in conjunction with 52000, 52276, 52281, 52601, 52647, 52648, 53020, 55250)</td>
</tr>
<tr>
<td>52700</td>
<td>Transurethral drainage of prostatic abscess</td>
</tr>
</tbody>
</table>

**URETHRA**

**INCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53000</td>
<td>Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra</td>
</tr>
<tr>
<td>53010</td>
<td>perineal urethra, external</td>
</tr>
<tr>
<td>53020</td>
<td>Meatotomy, cutting of meatus (separate procedure); except infant</td>
</tr>
<tr>
<td>53025</td>
<td>infant</td>
</tr>
</tbody>
</table>
(Do not report modifier -63 in conjunction with 53025)

53040 Drainage of deep periurethral abscess
53060 Drainage of Skene's gland abscess or cyst
53080 Drainage of perineal urinary extravasation; uncomplicated (separate procedure)
53085  complicated

**EXCISION**

53200 Biopsy of urethra
53210 Urethrectomy, total, including cystostomy; female
53215  male
53220 Excision or fulguration of carcinoma of urethra
53230 Excision of urethral diverticulum (separate procedure); female
53235  male
53240 Marsupialization of urethral diverticulum, male or female
53250 Excision of bulbourethral gland (Cowper's gland)
53260 Excision or fulguration; urethral polyp(s), distal urethra
53265  urethral caruncle
53270  Skene's glands
53275  urethral prolapse

**REPAIR**

53400 Urethroplasty; first stage, for fistula, diverticulum, or stricture, (eg, Johannsen type)
53405  second stage (formation of urethra), including urinary diversion
53410 Urethroplasty, one-stage reconstruction of male anterior urethra
53415 Urethroplasty, transpubic or perineal, one stage, for reconstruction or repair of prostatic or membranous urethra
53420 Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425  second stage
53430 Urethroplasty, reconstruction of female urethra
53431 Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg, Tenago, Leadbetter procedure)
53440 Sling operation for correction of male urinary incontinence, (eg, fascia or synthetic)
53442 Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)
53444 Insertion of tandem cuff (dual cuff)
53445 Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
53446 Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53447 Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir and cuff at the same operative session
53448 Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue
(Do not report 11043 in addition to 53448)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53449</td>
<td>Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff</td>
</tr>
<tr>
<td>53450</td>
<td>Urethromeatoplasty, with mucosal advancement</td>
</tr>
<tr>
<td>53460</td>
<td>Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)</td>
</tr>
<tr>
<td>53500</td>
<td>Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring) (Do not report 53500 in conjunction with 52000)</td>
</tr>
<tr>
<td>53502</td>
<td>Urethorrhaphy, suture of urethral wound or injury; female</td>
</tr>
<tr>
<td>53505</td>
<td>penile</td>
</tr>
<tr>
<td>53510</td>
<td>perineal</td>
</tr>
<tr>
<td>53515</td>
<td>prostatomembranous</td>
</tr>
<tr>
<td>53520</td>
<td>Closure of urethroscopy or urethrocutaneous fistula, male (separate procedure)</td>
</tr>
</tbody>
</table>

### MANIPULATION

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53600</td>
<td>Dilation of urethral stricture by passage of sound or urethral dilator, male; initial</td>
</tr>
<tr>
<td>53601</td>
<td>subsequent</td>
</tr>
<tr>
<td>53605</td>
<td>Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia</td>
</tr>
<tr>
<td>53620</td>
<td>Dilation of urethral stricture by passage of filiform and follower, male; initial</td>
</tr>
<tr>
<td>53621</td>
<td>subsequent</td>
</tr>
<tr>
<td>53660</td>
<td>Dilation of female urethra including suppository and/or instillation; initial</td>
</tr>
<tr>
<td>53661</td>
<td>subsequent</td>
</tr>
<tr>
<td>53665</td>
<td>Dilation of female urethra, general or conduction (spinal) anesthesia</td>
</tr>
</tbody>
</table>

### OTHER PROCEDURES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53850</td>
<td>Transurethral destruction of prostate tissue; by microwave thermotherapy</td>
</tr>
<tr>
<td>53852</td>
<td>by radiofrequency thermotherapy</td>
</tr>
<tr>
<td>53855</td>
<td>Insertion of a temporary prostatic urethral stent, including urethral measurement</td>
</tr>
<tr>
<td>53860</td>
<td>Transurethral radiofrequency micro-modeling of the female bladder neck and proximal urethra for stress urinary incontinence</td>
</tr>
<tr>
<td>53899</td>
<td>Unlisted procedure, urinary system</td>
</tr>
</tbody>
</table>

### MALE GENITAL SYSTEM

#### PENIS

### INCISION

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54000</td>
<td>Slitting of prepuce, dorsal or lateral (separate procedure); newborn</td>
</tr>
<tr>
<td></td>
<td>(Do not report modifier –63 in conjunction with 54000)</td>
</tr>
<tr>
<td>54001</td>
<td>except newborn</td>
</tr>
<tr>
<td>54015</td>
<td>Incision and drainage of penis, deep</td>
</tr>
</tbody>
</table>

### DESTRUCTION
54050  Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
54055  electrodesiccation
54056  cryosurgery
54057  laser surgery
54060  surgical excision
54065  Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

EXCISION

54100  Biopsy of penis; (separate procedure)
54105  deep structures
54110  Excision of penile plaque (Peyronie disease);
54111  with graft to 5 cm in length
54112  with graft greater than 5 cm in length
54115  Removal foreign body from deep penile tissue (eg, plastic implant)
54120  Amputation of penis; partial
54125  complete
54130  Amputation of penis, radical; with bilateral inguinofemoral lymphadenectomy
54135  in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
54150  Circumcision, using clamp or other device with regional dorsal penile or ring block
(Do not report modifier 63 in conjunction with 54150)
54160  Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less)
(Do not report modifier 63 in conjunction with 54160)
54161  older than 28 days of age
54162  Lysis or excision of penile post-circumcision adhesions
54163  Repair incomplete circumcision
54164  Frenulotomy of penis
(Do not report 54164 with circumcision codes 54150-54161, 54162, 54163)

INTRODUCTION

54200  Injection procedure for Peyronie disease;
54205  with surgical exposure of plaque
54220  Irrigation of corpora cavernosa for priapism
54230  Injection procedure for corpora cavernosography
54240  Penile plethysmography
54250  Nocturnal penile tumescence and/or rigidity test

REPAIR

54300  Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra
54304 Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps

54308 Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm

54312 greater than 3 cm

54316 Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia

54318 Urethroplasty for third stage hypospadias repair to release penis from scrotum (eg, 3rd stage Cecil repair)

54322 One stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V-flap)

54324 with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap)

54326 with urethroplasty by local skin flaps and mobilization of urethra

54328 with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap

54332 One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap

54336 One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap

54340 Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple

54344 requiring mobilization of skin flaps and urethroplasty with flap or patch graft

54348 requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)

54352 Repair of hypospadias cripple requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as flaps or grafts

54360 Plastic operation on penis to correct angulation

54380 Plastic operation on penis for epispadias distal to external sphincter;

54385 with incontinence

54390 with exstrophy of bladder

54400 Insertion of penile prosthesis; non-inflatable (semi-rigid)

54401 inflatable (self-contained)

54405 Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir

54406 Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis

54408 Repair of component(s) of a multi-component, inflatable penile prosthesis

54410 Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session

54411 Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue

(Do not report 11043 in addition to 54411)
54415  Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416  Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417  Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
   (Do not report 11043 in addition to 54417)
54420  Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral
54430  Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilateral
54435  Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism
54437  Repair of traumatic corporeal tear(s)
54438  Replantation, penis, complete amputation including urethral repair
54440  Plastic operation of penis for injury

MANIPULATION

54450  Foreskin manipulation including lysis of preputial adhesions and stretching

TESTIS

EXCISION

54500  Biopsy of testis, needle (separate procedure)
54505  Biopsy of testis, incisional (separate procedure)
   (For bilateral procedure, use modifier -50)
54512  Excision of extraparenchymal lesion of testis
54520  Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
   (For bilateral procedure, use modifier -50)
54522  Orchiectomy, partial
54530  Orchiectomy, radical, for tumor; inguinal approach
54535  with abdominal exploration

EXPLORATION

(For 54550, 54560 for bilateral procedure, use modifier -50)

54550  Exploration for undescended testis (inguinal or scrotal area)
54560  Exploration for undescended testis with abdominal exploration

REPAIR

54600  Reduction of torsion of testis, surgical, with or without fixation of contralateral testis
54620  Fixation of contralateral testis (separate procedure)
54640  Orchiopexy, inguinal approach, with or without hernia repair
   (For bilateral procedure, use modifier 50)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54650</td>
<td>Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)</td>
</tr>
</tbody>
</table>
| 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>54690</td>
<td>Laparoscopy, surgical; orchiectomy</td>
</tr>
<tr>
<td>54692</td>
<td>Orchiopexy for intra-abdominal testis</td>
</tr>
<tr>
<td>54699</td>
<td>Unlisted laparoscopy procedure, testis</td>
</tr>
</tbody>
</table>

**EPIDIDYMIS**

**INCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54700</td>
<td>Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)</td>
</tr>
</tbody>
</table>

**EXCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54800</td>
<td>Biopsy of epididymis, needle</td>
</tr>
<tr>
<td>54830</td>
<td>Excision of local lesion of epididymis</td>
</tr>
<tr>
<td>54840</td>
<td>Excision of spermatocele, with or without epididymectomy</td>
</tr>
<tr>
<td>54860</td>
<td>Epididymectomy; unilateral</td>
</tr>
<tr>
<td>54861</td>
<td>Bilateral</td>
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</tbody>
</table>

**EXPLORATION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54865</td>
<td>Exploration of epididymis, with or without biopsy</td>
</tr>
</tbody>
</table>

**TUNICA VAGINALIS**

**INCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>55000</td>
<td>Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication</td>
</tr>
</tbody>
</table>

**EXCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>55040</td>
<td>Excision of hydrocele; unilateral</td>
</tr>
<tr>
<td>55041</td>
<td>Bilateral</td>
</tr>
</tbody>
</table>

**REPAIR**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>55060</td>
<td>Repair of tunica vaginalis hydrocele (Bottle type)</td>
</tr>
</tbody>
</table>

**SCROTUM**

**INCISION**
Physician - Procedure Codes, Section 5 - Surgery

55100 Drainage of scrotal wall abscess
   (See also 54700)
55110 Scrotal exploration
55120 Removal of foreign body in scrotum

EXCISION
55150 Resection of scrotum

REPAIR
55175 Scrotoplasty; simple
55180 complicated

VAS DEFERENS

INCISION
55200 Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)

EXCISION
55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)

SPERMATIC CORD

EXCISION
55500 Excision of hydrocele of spermatic cord, unilateral (separate procedure)
55520 Excision of lesion of spermatic cord (separate procedure)
55530 Excision of varicocele or ligation of spermatic veins for varicocele;
   (separate procedure)
55535 abdominal approach
55540 with hernia repair

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.
55550 Laparoscopy, surgical, with ligation of spermatic veins for varicocele
55559 Unlisted laparoscopy procedure, spermatic cord

SEMINAL VESICLES

INCISION
55600 Vesiculotomy;
   (For bilateral procedure, use modifier 50)
55605 complicated

EXCISION
55650 Vesiculectomy, any approach
   (For bilateral procedure, use modifier 50)
55680 Excision of Mullerian duct cyst

PROSTATE
INCISION
55700 Biopsy, prostate; needle or punch, single or multiple, any approach
55705 incisional, any approach
55720 Prostatotomy, external drainage of prostatic abscess, any approach; simple
55725 complicated

EXCISION
55801 Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)
55810 Prostatectomy, perineal radical;
55812 with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55815 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
   (If 55815 is carried out on separate days, use 38770 and 55810)
55821 Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, one or two stages
55831 retropubic, subtotal
55840 Prostatectomy, retropubic radical, with or without nerve sparing;
55842 with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55845 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
   (If 55845 is carried out on separate days, use 38770 and 55840)
55860 Exposure of prostate, any approach, for insertion of radioactive substance;
55862 with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55865 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes

LAPAROSCOPY
Surgical laparoscopy always includes diagnostic laparoscopy.
55866 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed

OTHER PROCEDURES
55873  Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)
55875  Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
55876  Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach, single or multiple
55899  Unlisted procedure, male genital system
A4648  Tissue marker, implantable, any type, each

REPRODUCTIVE SYSTEM PROCEDURES
55920  Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application

INTERSEX SURGERY
GENDER REASSIGNMENT SURGERY
55970  Intersex surgery; male to female
55980  female to male

Physicians performing gender reassignment surgery will submit paper claims billing either code 55970 (intersex surgery; male to female) or 55980 (intersex surgery; female to male). These procedure codes are only appropriate for individuals with a diagnosis of gender dysphoria. The physician must include with the paper claim the operation report and copies of the two letters from New York State licensed health practitioners recommending the patient for surgery (see June 2015 Medicaid Update). Practitioners must submit charges on an invoice for review/payment.

When reporting procedure code 55970 for New York State Medicaid members, the following staged procedures to remove portions of the male genitalia and form female external genitalia are included as applicable:

- The penis is dissected, and portions are removed with care to preserve vital nerves and vessels in order to fashion a clitoris-like structure.
- The urethral opening is moved to a position similar to that of a female.
- A vagina is made by dissecting and opening the perineum. This opening is lined using pedicle or split-thickness grafts.
- Labia are created out of skin from the scrotum and adjacent tissue.
- A stent or obturator is usually left in place in the newly created vagina for three weeks or longer.
- Hair removal, if clinically indicated, is included in payment for this procedure.

Vaginal dilators ancillary to this surgical procedure dispensed by a provider may be billed as a medical supply with code 99070. Please see the Surgery – General Instructions section at the beginning of this manual for instructions on how to bill 99070.

When reporting procedure code 55980 for New York State Medicaid members, the physician will have to identify if a phalloplasty or metoidioplasty was performed. The following staged procedures are included, if applicable, when reporting 55980:

- Portions of the clitoris are used, as well as the adjacent skin.
- Prostheses are often placed in the penis to create a sexually functional organ.
• Prosthetic testicles are implanted in the scrotum.
• The urethral opening is moved to a position similar to that of a male.
• The vagina is closed or removed.
• Hair removal, if clinically indicated, is included in payment for this procedure.

When performing the following procedures for the purpose of gender reassignment, physicians must obtain and maintain in their records copies of the two letters from New York State licensed health practitioners recommending the patient for surgery (see June 2015 Medicaid Update). These procedures, when medically necessary, do not require prior approval or paper claim submission:

19303: Mastectomy, simple, complete
19304: Mastectomy, subcutaneous
19318: Reduction mammoplasty (unilateral)
19324: Mammaplasty, augmentation; without prosthetic implant
19325: with prosthetic implant

For male-to-female gender reassignment, augmentation mammoplasty may be considered medically necessary for individuals with a diagnosis of gender dysphoria when that individual does not have any breast growth after 24 months of cross-sex hormone therapy, or in instances where hormone therapy is medically contraindicated.

54520: Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54522: Orchiectomy, partial
58150: Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58152: with colpo-urethrocystopexy (e.g., Marshall-Machetti-Krantz, Burch)
58180: Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260: Vaginal hysterectomy, for uterus 250 grams or less;
58262: with removal of tube(s), and/or ovary(s)
58263: with removal of tube(s), and/or ovary(s), with repair of enterocele
58267: with colpo-urethrocystopexy (Marshall-Marchetti-Krantz Type, Pereyra type, with or without endoscopic control)
58270: with repair of enterocele
58275: Vaginal hysterectomy, with total or partial vaginectomy;
58280: with repair of enterocele
58285: Vaginal hysterectomy, radical (Schauta type operation)
58290: Vaginal hysterectomy, for uterus greater than 250 grams;
58291: with removal of tube(s) and/or ovary(s)
58292: with removal of tube(s) and/or ovary(s), with repair of enterocele
58293: with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58294: with repair of enterocele

See General Information and Rules Section at the beginning of this manual for additional instructions for billing hysterectomy codes, including information on the "Hysterectomy Receipt of Information Form."
58720: Salpingo-oophorectomy, complete or partial, unilateral or bilateral
58940: Oophorectomy, partial or total, unilateral or bilateral

When performing the following procedures for purposes of gender reassignment, prior approval is required. As part of the prior approval request, physicians must, at a minimum, submit copies of the two letters from New York State licensed health practitioners recommending the patient for surgery (see June 2015 Medicaid Update), and additional justification of medical necessity for the requested procedure. Information about the prior approval process, including instructions for providers, is available in the Physician Prior Approval Guidelines manual, available at: https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician_PA_Guidelines.pdf.

11950: Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951: 1.1 to 5 cc
11952: 5.1 to 10 cc
11954: over 10 cc
15775: Punch graft for hair transplant; 1 to 15 punch grafts
15776: more than 15 punch grafts
15820: Blepharoplasty, lower eyelid;
15821: with extensive herniated fat pad
15822: Blepharoplasty, upper eyelid;
15823: with excessive skin weighting down lid
15824: Rhytidectomy; forehead
15825: neck with platysmal tightening (platysmal flap, P-flap)
15826: glabellar frown lines
15828: cheek, chin, and neck
15830: Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832: thigh
15833: leg
15834: hip
15835: buttock
15836: arm
15837: forearm or hand
15838: submental fat pad
15839: other area
15847: Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
15876: Suction assisted lipectomy; head and neck
15877: trunk
15878: upper extremity
15879: lower extremity
17380: Electrolysis epilation, each 30 minutes
19316: Mastopexy (unilateral)
21120: Genioplasty; augmentation (autograft, allograft, prosthetic material)
21123: sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21193: Reconstruction of mandibular rami, horizontal, vertical, "C", or "L" osteotomy; without bone graft
21208: Osteoplasty, facial bones; augmentation (autograft, allograft or prosthetic implant)
21209: reduction
21270: Malar augmentation, prosthetic material
30400: Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410: complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420: including major septal repair
30430: Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435: intermediate revision (bony work with osteotomies)
30450: major revision (nasal tip work and osteotomies)
30462: tip, septum, osteotomies
30465: Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
31599: Unlisted procedure, larynx
40500: Vermiliencectomy (lip shave), with mucosal advancement
67900: Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

FEMALE GENITAL SYSTEM

VULVA, PERINEUM AND INTROITUS

The following definitions apply to the vulvectomy codes (56620-56640):
Simple: The removal of skin and superficial subcutaneous tissue.
Radical: The removal of skin and deep subcutaneous tissue.
Partial: Removal of less than 80% of the vulvar area.
Complete: The removal of greater than 80% of the vulvar area.

INCISION

56405 Incision and drainage of vulva or perineal abscess
56420 Incision and drainage of Bartholin's gland abscess
56440 Marsupialization of Bartholin's gland cyst
56441 Lysis of labial adhesions
56442 Hymenotomy, simple incision

DESTRUCTION

56501 Destruction of lesion(s), vulva; simple, (laser surgery, electrosurgery, cryosurgery, chemosurgery)
56515 extensive, (laser surgery, electrosurgery, cryosurgery, chemosurgery)

EXCISION

56605 Biopsy of vulva or perineum. (separate procedure); one lesion
56606 each separate additional lesion
(Use 56606 in conjunction with 56605)
56620  Vulvectomy simple; partial
56625  complete
56630  Vulvectomy, radical, partial;
56631  with unilateral inguinofemoral lymphadenectomy
56632  with bilateral inguinofemoral lymphadenectomy
56633  Vulvectomy, radical, complete;
56634  with unilateral inguinofemoral lymphadenectomy
56637  with bilateral inguinofemoral lymphadenectomy
56640  Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy
   (For bilateral procedure, use modifier 50)
56700  Partial hymenectomy or revision of hymenal ring
56740  Excision of Bartholin's gland or cyst

REPAIR

56800  Plastic repair of introitus
56805  Clitoroplasty for intersex state
56810  Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
   (See also 56800)

ENDOSCOPY

56820  Colposcopy of the vulva;
56821  with biopsy(s)

VAGINA

INCISION

57000  Colpotomy; with exploration
57010  with drainage of pelvic abscess
57020  Colpocentesis (separate procedure)
57022  Incision and drainage of vaginal hematoma; obstetrical/post-partum
57023  non-obstetrical (eg, post-trauma, spontaneous bleeding)

DESTRUCTION

57061  Destruction of vaginal lesion(s); simple, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
57065  extensive, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

EXCISION

57100  Biopsy of vaginal mucosa; simple (separate procedure)
57105  extensive, requiring suture (including cysts)
57106  Vaginectomy, partial removal of vaginal wall;
57107  with removal of paravaginal tissue (radical vaginectomy)
57109  with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)
57110 Vaginectomy, complete removal of vaginal wall;
57111  with removal of paravaginal tissue (radical vaginectomy)
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 tandem and/or vaginal ovoids for clinical brachytherapy
57156 Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy
57160 Fitting and insertion of pessary or other intravaginal support device
57180 Introduction of any hemostatic agent or pack for spontaneous or traumatic nonobstetrical
hemorrhage (separate procedure)

REPAIR

57200 Colporrhaphy, suture of injury of vagina (nonobstetrical)
57210 Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical)
57220 Plastic operation on urethral sphincter, vaginal approach (eg, Kelly urethral plication)
57230 Plastic repair of urethrocele
57240 Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele,
including cystourethroscopy, when performed
57250 Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy
57260 Combined anteroposterior colporrhaphy; including cystourethroscopy, when performed;
57265  with enterocoele repair
57267 Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior,
posterior compartment), vaginal approach
   (List separately in addition to primary procedure)
57268 Repair of enterocoele, vaginal approach (separate procedure)
57270 Repair of enterocoele, abdominal approach (separate procedure)
57280 Colpopexy, abdominal approach
57282 Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)
57283  intra-peritoneal approach (uterosacral, levator myorrhaphy)
57284 Paravaginal defect repair (including repair of cystocele, if performed); open abdominal
approach
   (Do not report 57284 in conjunction with 51840, 51841, 51990, 57240, 57260, 57265, 58152,
58267)
57285  vaginal approach
   (Do not report 57285 in conjunction with 51990, 57240, 57260, 57265, 58267)
57287 Removal or revision of sling for stress incontinence (eg, fascia or synthetic)
57288 Sling operation for stress incontinence (eg, fascia or synthetic)
57289 Pereyra procedure, including anterior colporrhaphy
57291 Construction of artificial vagina; without graft
57292 with graft
57295 Revision (including removal) of prosthetic vaginal graft, vaginal approach
57296 open abdominal approach
57300 Closure of rectovaginal fistula; vaginal or transanal approach
57305 abdominal approach
57307 abdominal approach, with concomitant colostomy
57308 transperineal approach, with perineal body reconstruction, with or without levator plication
57310 Closure of urethrovaginal fistula;
57311 with bulbocavernosus transplant
57320 Closure of vesicovaginal fistula; vaginal approach
57330 transvesical and vaginal approach
57335 Vaginoplasty for intersex state

MANIPULATION

57400 Dilation of vagina under anesthesia (other than local)
57410 Pelvic examination under anesthesia (other than local)
57415 Removal of impacted vaginal foreign body (separate procedure) under anesthesia (other than local)
(For removal without anesthesia of an impacted vaginal foreign body, use the appropriate Evaluation and Management code)

ENDOSCOPY

57420 Colposcopy of the entire vagina, with cervix if present;
57421 with biopsy(s) of vagina/cervix
57423 Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach
(Do not report 57423 in conjunction with 49320, 51840, 51841, 51990, 57240, 57260, 58152, 58267)
57425 Laparoscopy, surgical, colpopexy (suspension of vaginal apex)
57426 Revision (including removal) of prosthetic vaginal graft, laparoscopic approach

CERVIX UTERI

ENDOSCOPY

57452 Colposcopy of the cervix including upper/adjacent vagina;
(Do not report 57452 in addition to 57454-57461)
57454 with biopsy(s) of the cervix and endocervical curettage
57455 with biopsy(s) of the cervix
57456 with endocervical curettage
57460 with loop electrode biopsy(s) of the cervix
57461 with loop electrode conization of the cervix
(Do not report 57461 in addition to 57461)
**EXCISION**

57500 Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
57505 Endocervical curettage (not done as part of a dilation and curettage)
57510 Cautery of cervix; electro or thermal
57511 cryocaustery, initial or repeat
57513 laser ablation
57520 Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser
   (See also 58120)
57522 loop electrode excision
57530 Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
57531 Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling biopsy, with or without removal of tube(s), with or without removal of ovary(s)
57540 Excision of cervical stump, abdominal approach;
57545     with pelvic floor repair
57550 Excision of cervical stump, vaginal approach;
57555     with anterior and/or posterior repair
57556     with repair of enterocele
57558 Dilation and curettage of cervical stump

**REPAIR**

57700 Cerclage of uterine cervix, nonobstetrical
57720 Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach

**MANIPULATION**

57800 Dilation of cervical canal, instrumental (separate procedure)

**CORPUS UTERI**

**EXCISION**

58100 Endometrial sampling (biopsy), with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
58110 Endometrial sampling (biopsy) performed in conjunction with colposcopy
   (List separately in addition to primary procedure)
   (Use 58110 in conjunction with 57420, 57421, 57452-57461)
58120 Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
58140 Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 grams or less and/or removal of surface myomas; abdominal approach
58145     vaginal approach
58146 Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach
   (Do not report 58146 in addition to 58140-58145, 58150-58240)
HYSTERECTOMY PROCEDURES

(For codes 58150-58294, See Rule 14, Receipt of Hysterectomy Information)

58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58152 with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)
58180 Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58200 Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)
58210 Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)
58240 Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
58260 Vaginal hysterectomy, for uterus 250 grams or less;
58262 with removal of tube(s), and/or ovary(s)
58263 with removal of tube(s), and/or ovary(s), with repair of enterocele
(Do not report 58263 in addition to 57283)
58267 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz Type, Pereyra type, with or without endoscopic control)
58270 with repair of enterocele
58275 Vaginal hysterectomy, with total or partial vaginectomy;
58280 with repair of enterocele
58285 Vaginal hysterectomy, radical (Schauta type operation)
58290 Vaginal hysterectomy, for uterus greater than 250 grams;
58291 with removal of tube(s) and/or ovary(s)
58292 with removal of tube(s) and/or ovary(s), with repair of enterocele
58293 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58294 with repair of enterocele

INTRODUCTION

58300 Insertion of intrauterine device (IUD)
58301 Removal of intrauterine device (IUD)
58340 Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (sis) or hysterosalpingography
58346 Insertion of Heyman capsules for clinical brachytherapy
58353 Endometrial ablation, thermal, without hysteroscopic guidance
58356 Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed

REPAIR
58400  Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)
58410  with presacral sympathectomy
58520  Hysterorrhaphy, repair of ruptured uterus (nonobstetrical)
58540  Hysteroplasty, repair of uterine anomaly (Strassman type)

**LAPAROSCOPY / HYSTEROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

*(For codes 58541-58544, 58548-58554, 58570-58573, See Rule 14, Receipt of Hysterectomy Information)*

*(For code 58565, See Rule 13, Informed Consent for Sterilization)*

58541  Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;  
58542    with removal of tube(s) and/or ovary(s)  
58543  Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;  
58544    with removal of tube(s) and/or ovary(s)  
58545  Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas  
58546    5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams  
58548  Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed  
(Do not report 58548 in conjunction with 38570-38572, 58210, 58285, 58550-58554)  
58550  Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less;  
58552    with removal of tube(s) and/or ovary(s)  
58553  Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;  
58554    with removal of tube(s) and/or ovary(s)  
58555  Hysteroscopy, diagnostic (separate procedure)  
58558  Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D&C  
58559    with lysis of intrauterine adhesions (any method)  
58560    with division or resection of intrauterine septum (any method)  
58561    with removal of leiomyomata  
58562    with removal of impacted foreign body  
58563    with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)  
58565    with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants  
(Do not report 58565 in conjunction with 58555 or 57800)  
A4264  Permanent implantable contraceptive intratubal occlusion device(s) and delivery system  
58570  Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;  
58571    with removal of tube(s) and/or ovary(s)
58572  Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
58573  with removal of tube(s) and/or ovary(s)
58575  Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking),
       with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed
58578  Unlisted laparoscopy procedure, uterus
58579  Unlisted hysteroscopy procedure, uterus

**OVIDUCT/OVARY**

**INCISION**

*(For codes 58600-58615, See Rule 13, Informed Consent for Sterilization)*

58600  Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or
       bilateral
58605  Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum,
       unilateral or bilateral, during same hospitalization (separate procedure)
58611  Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or
       intra-abdominal surgery (not a separate procedure)
       (List separately in addition to primary procedure)
58615  Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic
       approach

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

*(For codes 58670, 58671, See Rule 13, Informed Consent for Sterilization)*

58660  Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate
       procedure)
58661  with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58662  with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface
       by any method
58670  with fulguration of oviducts (with or without transection)
58671  with occlusion of oviducts by device (eg, band, clip, or Falope ring)
58673  with salpingostomy (salpingoneostomy)
       (Code 58673 is used to report unilateral procedures, for bilateral procedure, use
       modifier -50)
58679  Unlisted laparoscopy procedure, oviduct, ovary

**EXCISION**

58700  Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720  Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

**REPAIR**

58740  Lysis of adhesions (salpingolysis, ovariolysis)
58770 Salpingostomy (salpingoneostomy)

**OVARY**

**INCISION**

58800 Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); vaginal approach
58805 abdominal approach
58820 Drainage of ovarian abscess; vaginal approach, open
58822 abdominal approach
58825 Transposition, ovary(s)

**EXCISION**

*(For codes 58951, 58953, 58954, 58956, See Rule 14, Receipt of Hysterectomy Information)*

58900 Biopsy of ovary, unilateral or bilateral (separate procedure)
58920 Wedge resection or bisection of ovary, unilateral or bilateral
58925 Ovarian cystectomy, unilateral or bilateral
58940 Oophorectomy, partial or total, unilateral or bilateral;
58943 for ovarian, tubal or primary peritoneal malignancy, with para aortic and pelvic lymph node biopsies, peritoneal washings, peritoneal biopsies, diaphragmatic assessments, with or without salpingectomy(s) with or without omentectomy
58950 Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy;
58951 with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy
58952 with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)
58953 Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;
58954 with pelvic lymphadenectomy and limited para-aortic lymphadenectomy
58956 Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy
(Do not report 58956 in conjunction with 49255, 58150, 58180, 58262, 58263, 58550, 58661, 58700, 58720, 58900, 58925, 58940, 58957, 58958)
58957 Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;
58958 with pelvic lymphadenectomy and limited para-aortic lymphadenectomy
(Do not report 58957, 58958 in conjunction with 38770, 38780, 44005, 49000, 49203-49215, 49255, 58900-58960)
58960 Laparotomy, for staging or restaging of ovarian, tubal or primary peritoneal malignancy (second look), with or without omentectomy, peritoneal washing, biopsy of abdominal and pelvic peritoneum, diaphragmatic assessment with pelvic and limited para-aortic lymphadenectomy
(Do not report 58960 in conjunction with 58957, 58958)
58999 Unlisted procedure, female genital system, nonobstetrical
MATERNITY CARE AND DELIVERY

The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care.

Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Any other visits or services within this time period should be coded separately.

Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. Medical problems complicating labor and delivery management may require additional resources and should be identified by utilizing the codes in the Medicine and E/M Services section in addition to codes for maternity care.

Postpartum care includes hospital and office visits following vaginal or cesarean section delivery.

For medical complications of pregnancy (eg, cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, pre-term labor, premature rupture of membranes), see services in the Medicine and E/M Services section. For surgical complications of pregnancy (eg, appendectomy, hernia, ovarian cyst, Bartholin cyst), see services in the Surgery section.

If a physician provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to termination of pregnancy by abortion or referral to another physician for delivery, see the antepartum and postpartum care codes 59425-59426 and 59430.

Reimbursement amounts for the Medicaid Obstetrical and Maternal Services Program (MOMS), are noted in the Enhanced Program excel Fee Schedule. For information on the MOMS Program, see Policy Section.

FETAL INVASIVE SERVICES

59000  Amniocentesis; diagnostic
59001  therapeutic amniotic fluid reduction (includes ultrasound guidance)
59012  Cordocentesis (intrauterine), any method
59015  Chorionic villus sampling, any method
59020  Fetal contraction stress test
59025  Fetal non-stress test
59030  Fetal scalp blood sampling
59050  Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation
59070  Transabdominal amnioinfusion, including ultrasound guidance
59072  Fetal umbilical cord occlusion, including ultrasound guidance
59074  Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance
59076  Fetal shunt placement, including ultrasound guidance

EXCISION
(For code 59135, See Rule 14, Receipt of Hysterectomy Information)

59100  Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)
(When tubal ligation is performed at the same time as hysterotomy, use 58611 in addition to 59100)

59120  Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach

59121  tubal or ovarian, without salpingectomy and/or oophorectomy

59130  abdominal pregnancy

59135  interstitial, uterine pregnancy requiring total hysterectomy

59136  interstitial, uterine pregnancy with partial resection of uterus

59140  cervical, with evacuation

59150  Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy

59151  with salpingectomy and/or oophorectomy

59160  Curettage, postpartum

INTRODUCTION

59200  Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)

REPAIR

59300  Episiotomy or vaginal repair, by other than attending

59320  Cerclage of cervix, during pregnancy; vaginal

59325  abdominal

59350  Hysterorrhaphy of ruptured uterus

VAGINAL DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

59400  Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and (inpatient and outpatient) postpartum care (total, all-inclusive, "global" care)

59409  Vaginal delivery only (with or without episiotomy and/or forceps); (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)

59410  including (inpatient and outpatient) postpartum care

59412  External cephalic version, with or without tocolysis

59414  Delivery of placenta (separate procedure)
(For antepartum care only, see 59425, 59426 or appropriate E/M code(s))
(For 1-3 antepartum care visits, see appropriate E/M code(s))

59425  Antepartum care only; 4-6 visits

59426  7 or more visits
(For 6 or less antepartum encounters, see code 59425)

Note: Antepartum services will no longer require prorated charges. This applies to all prenatal care providers, including those enrolled in the MOMS program. Providers should bill one unit of the appropriate antepartum code after all antepartum care has been rendered
using the last antepartum visit as the date of service. Only one antepartum care code will be reimbursed per pregnancy.

59430 Postpartum care only (outpatient) (separate procedure)

**CESAREAN DELIVERY**

59510 Routine obstetric care including antepartum care, cesarean delivery, and (inpatient and outpatient) postpartum care (total, all-inclusive, "global" care)

59514 Cesarean delivery only; (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)

59515 including (inpatient and outpatient) postpartum care

59525 Subtotal or total hysterectomy after cesarean delivery *(See Rule 14)*
(List separately in addition to primary procedure)
(Use 59525 in conjunction with 59510, 59514, 59515, or 59618, 59620, 59622)

**DELIVERY AFTER PREVIOUS CESAREAN DELIVERY**

Patients who have had a previous cesarean delivery and now present with the expectation of a vaginal delivery are coded using codes 59610-59622. If the patient has a successful vaginal delivery after a previous cesarean delivery (VBAC), use codes 59610-59614. If the attempt is unsuccessful and another cesarean delivery is carried out, use codes 59618-59622. To report elective cesarean deliveries use code 59510, 59514 or 59515.

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and (inpatient and outpatient) postpartum care, after previous cesarean delivery (total, all-inclusive, "global" care)

59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)

59614 including (inpatient and outpatient) postpartum care

59618 Routine obstetric care including antepartum care, cesarean delivery, and (inpatient and outpatient) postpartum care, following attempted vaginal delivery after previous cesarean delivery (total, all-inclusive, "global" care)

59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)

59622 including (inpatient and outpatient) postpartum care

**ABORTION**

(Ultrasound service(s) provided in conjunction with procedure codes 59812 through 59857 are reimbursable **ONLY** via echography code 76815. Procedure code 76815 should be billed regardless of the approach used to perform the ultrasound (eg, transvaginal))

59812 Treatment of incomplete abortion, any trimester, completed surgically

59820 Treatment of missed abortion, completed surgically; first trimester

59821 second trimester
59830  Treatment of septic abortion, completed surgically
59840  Induced abortion, by dilation and curettage
59841  Induced abortion, by dilation and evacuation
59850  Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;
59851    with dilation and curettage and/or evacuation
59852    with hysterotomy (failed intra-amniotic injection)
59855  Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;
59856    with dilation and curettage and/or evacuation
59857    with hysterotomy (failed medical evaluation)

OTHER PROCEDURES

59870  Uterine evacuation and curettage for hydatidiform mole
59871  Removal of cerclage suture under anesthesia (other than local)
59897  Unlisted fetal invasive procedure, including ultrasound guidance, when performed
59898  Unlisted laparoscopy procedure, maternity care and delivery
59899  Unlisted procedure, maternity care and delivery

ENDOCRINE SYSTEM

THYROID GLAND

INCISION

60000  Incision and drainage of thyroglossal duct cyst, infected

EXCISION

60100  Biopsy thyroid, percutaneous core needle
60200  Excision of cyst or adenoma of thyroid, or transection of isthmus
60210  Partial thyroid lobectomy, unilateral; with or without isthmusectomy
60212    with contralateral subtotal lobectomy, including isthmusectomy
60220  Total thyroid lobectomy, unilateral; with or without isthmusectomy
60225    with contralateral subtotal lobectomy, including isthmusectomy
60240  Thyroidectomy, total or complete
60252  Thyroidectomy, total or subtotal for malignancy; with limited neck dissection
60254    with radical neck dissection
60260  Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid
    (For bilateral procedure, use modifier -50)
60270  Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach
60271    cervical approach
60280  Excision of thyroglossal duct cyst or sinus;
60281    recurrent
REMOVAL

60300  Aspiration and/or injection, thyroid cyst

PARATHYROID, THYMUS, ADRENAL GLANDS, PANCREAS, AND CARTOID BODY

EXCISION

60500  Parathyroidectomy or exploration of parathyroid(s);
60502   re-exploration
60505   with mediastinal exploration, sternal split or transthoracic approach
60512  Parathyroid autotransplantation
   (List separately in addition to primary procedure)
   (Use 60512 in conjunction with codes 60500, 60502, 60505, 60212, 60225, 60240, 60252,
   60254, 60260, 60270, 60271)
60520  Thymectomy, partial or total; transcervical approach (separate procedure)
60521   sternal split or total; transcervical approach, without radical mediastinal dissection (separate procedure)
60522   sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)
60540  Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure);
60545   with excision of adjacent retroperitoneal tumor
   (For bilateral procedure, use modifier -50)
   (For laparoscopic approach, use 60650)
60600  Excision of carotid body tumor; without excision of carotid artery
60605   with excision of carotid artery

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

60650  Laparoscopy, surgical; with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal
60659  Unlisted laparoscopy procedure, endocrine system

OTHER PROCEDURES

60699  Unlisted procedure, endocrine system

NERVOUS SYSTEM

SKULL, MENINGES, AND BRAIN

INJECTION, DRAINAGE OR ASPIRATION

61000  Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initial
61001   subsequent taps
61020  Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection
61026  with injection of medicament or other substance for diagnosis or treatment
61050  Cisternal or lateral cervical (CI-C2) puncture; without injection (separate procedure)
61055  with injection of medication or other substance for diagnosis or treatment
61070  Puncture of shunt tubing or reservoir for aspiration or injection procedure
(For radiological supervision and interpretation, use 75809)

TWIST DRILL, BURR HOLE(S) OR TREPHINE
(For codes 61107, 61210 for intracranial neuroendoscopic ventricular catheter placement, use 62160)

61105  Twist drill hole for subdural or ventricular puncture;
61107  Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for implanting ventricular catheter, pressure recording device, or other intracerebral monitoring device
61108  for evacuation and/or drainage of subdural hematoma
61120  Burr hole(s) for ventricular puncture (including injection of gas, contrast media, dye or radioactive material);
61140  Burr hole(s) or trephine; with biopsy of brain or intracranial lesion
61150  with drainage of brain abscess or cyst
61151  with subsequent tapping (aspiration) of intracranial abscess or cyst
61154  Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural
(For bilateral procedure, use modifier -50)
61156  Burr hole(s); with aspiration of hematoma or cyst, intracerebral
61210  for implanting ventricular catheter, reservoir, EEG electrode(s), pressure recording device, or other cerebral monitoring device (separate procedure)
61215  Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to ventricular catheter
61250  Burr hole(s) or trephine, supratentorial, exploratory, not followed by other surgery
(For bilateral procedure, use modifier -50)
61253  Burr hole(s) or trephine, infratentorial, unilateral or bilateral
(If burr hole(s) or trephine followed by craniotomy at same operative session use 61304-61321; do not use 61250 or 61253)

CRANIECTOMY OR CRANIOTOMY

61304  Craniectomy or craniotomy, exploratory; supratentorial
61305  infratentorial (posterior fossa)
61312  Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural
61313  intracerebral
61314  Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural
61315  intracerebellar
61316  Incision and subcutaneous placement of cranial bone graft
(List separately in addition to primary procedure)
(Use 61316 in conjunction with codes 61304, 61312, 61313, 61322, 61323, 61340, 61570, 61571, 61680-61705)
61320  Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial
61321  infratentorial
61322 Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy
61323 with lobectomy
(Do not report 61313 in addition to 61322, 61323)
61330 Decompression of orbit only, transcranial approach
(For bilateral procedure, use modifier -50)
61333 Exploration of orbit (transcranial approach) with removal of lesion
61340 Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome)
(For bilateral procedure, use modifier -50)
61343 Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft (eg, Arnold-Chiari malformation)
61345 Other cranial decompression, posterior fossa
61450 Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion
61458 Craniectomy, suboccipital; for exploration or decompression of cranial nerves
61460 for section of one or more cranial nerves
61500 Craniectomy; with excision of tumor or other bone lesion of skull
61501 for osteomyelitis
61510 Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma
61512 for excision of meningioma, supratentorial
61514 for excision of brain abscess, supratentorial
61516 for excision or fenestration of cyst, supratentorial
61517 Implantation of brain intracavitary chemotherapy agent
(List separately in addition to primary procedure)
(Use 61517 only in conjunction with codes 61510 or 61518)
(Do not report 61517 for brachytherapy insertion. For intracavitary insertion of radioelement sources or ribbons, see 77781-77784)
61518 Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull
61519 meningioma
61520 cerebellopontine angle tumor
61521 midline tumor at base of skull
61522 Craniectomy, infratentorial or posterior fossa; for excision of brain abscess
61524 for excision or fenestration of cyst
61526 Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;
61530 combined with middle/posterior fossa craniotomy/craniectomy
61531 Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring
61533 Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring
61534 for excision of epileptogenic focus without electrocorticography during surgery
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61535  for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)
61536  for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)
61537  for lobectomy, temporal lobe, without electrocorticography during surgery
61538  for lobectomy, temporal lobe, with electrocorticography during surgery
61539  for lobectomy, other than temporal lobe, partial or total with electrocorticography during surgery
61540  for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery
61541  for transection of corpus callosum
61543  for partial or subtotal (functional) hemispherectomy
61544  for excision or coagulation of choroid plexus
61545  for excision of craniopharyngioma
61546  Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach
61548  Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic
61550  Craniectomy for craniosynostosis; single cranial suture
61552  multiple cranial sutures
61556  Craniotomy for craniosynostosis; frontal or parietal bone flap
61557  bifrontal bone flap
61558  Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); not requiring bone grafts
61559  recontouring with multiple osteotomies and bone autografts (eg, barrel-stave procedure) (includes obtaining grafts)
61563  Excision, intra- and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); without optic nerve decompression
61564  with optic nerve decompression
61566  Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy
61567  for multiple subpial transections, with electrocorticography during surgery
61570  Craniectomy or craniotomy; with excision of foreign body from brain
61571  with treatment of penetrating wound of brain
61575  Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion;
61576  requiring splitting of tongue and/or mandible (including tracheostomy)

SURGERY OF SKULL BASE

The surgical management of lesions involving the skull base (base of anterior, middle and posterior cranial fossae) often requires the skills of several surgeons of different surgical specialties working together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of dura, subcutaneous tissues and skin to avoid serious infections such as osteomyelitis and/or meningitis.

The procedures are categorized according to 1) approach procedure necessary to obtain adequate exposure to the lesion (pathologic entity), 2) definitive procedure(s) necessary to biopsy, excise or
otherwise treat the lesion, and 3) **repair/reconstruction** of the defect present following the definitive procedure(s).

The **approach procedure** is described according to anatomical area involved, ie, anterior cranial fossa, middle cranial fossa, posterior cranial fossa and brain stem or upper spinal cord.

The **definitive procedure(s)** describes the repair, biopsy, resection or excision of various lesions of the skull base and, when appropriate, primary closure of the dura, mucous membranes and skin.

The **repair/reconstruction procedure(s)** is reported separately if extensive dural grafting, cranioplasty, local or regional myocutaneous pedicle flaps, or extensive skin grafts are required.

When one surgeon performs the approach procedure, another surgeon performs the definitive procedure, and another surgeon performs the repair/reconstruction procedure, each surgeon reports only the code for the specific procedure performed.

**APPROACH PROCEDURES**

61580 Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration

61581 extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy

61582 extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa

61583 intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa

61584 Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); without orbital exenteration

61585 with orbital exenteration

61586 Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft

61590 Infratemporal pre-auricular approach to middle cranial fossa (parapharyngeal space, infratemporal and midline skull base, nasopharynx), with or without disarticulation of the mandible, including parotidectomy, craniotomy, decompression and/or mobilization of the facial nerve and/or petrous carotid artery

61591 Infratemporal post-auricular approach to middle cranial fossa (internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, infratemporal fossa) including mastoidectomy, resection of sigmoid sinus, with or without decompression and/or mobilization of contents of auditory canal or petrous carotid artery

61592 Orbitocranial zygomatic approach to middle cranial fossa (cavernous sinus and carotid artery, clivus, basilar artery or petrous apex) including osteotomy of zygoma, craniotomy, extra- or intradural elevation of temporal lobe

61595 Transtemporal approach to posterior cranial fossa, jugular foramen or midline skull base, including mastoidectomy, decompression of sigmoid sinus and/or facial nerve, with or without mobilization

61596 Transcochlear approach to posterior cranial fossa, jugular foramen or midline skull base, including labyrinthectomy, decompression, with or without mobilization of facial nerve and/or petrous carotid artery
61597 Transcondylar (far lateral) approach to posterior cranial fossa, jugular foramen or midline skull base including occipital condylectomy, mastoidectomy, resection of Cl-C3 vertebral body(s), decompression of vertebral artery, with or without mobilization

61598 Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus

**DEFINITIVE PROCEDURES**

61600 Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; extradural

61601 intradural, including dural repair, with or without graft

61605 Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural

61606 intradural, including dural repair, with or without graft

61607 Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural

61608 intradural, including dural repair, with or without graft

61611 Transection or ligation, carotid artery in petrous canal; without repair

(List separately in addition to primary procedure)

61613 Obliteration of carotid aneurysm, arteriovenous malformation, or carotid-cavernous fistula by dissection within cavernous sinus

61615 Resection or excision of neoplastic vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or 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

61624 Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

(See also 37204)
61626  non-central nervous system, head or neck (extracranial, brachiocephalic branch)  
(See also 37204)
61630  Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous
61635  Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis),
including balloon angioplasty, if performed
(61630 and 61635 include all selective vascular catheterization of the target vascular family,
all diagnostic imaging for arteriography of the target vascular family, and all related
radiological supervision and interpretation. When diagnostic arteriogram (including imaging
and selective catheterization) confirms the need for angioplasty or stent placement, 61630
and 61635 are inclusive of these services. If angioplasty or stenting are not indicated, then
the appropriate codes for selective catheterization and imaging should be reported in lieu of
61630 and 61635)
61640  Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel
61641  each additional vessel in same vascular territory
(List separately in addition to primary procedure)
61642  each additional vessel in different vascular territory
(List separately in addition to primary procedure)
(Use 61641 and 61642 in conjunction with 61640)
(61640, 61641, 61642 include all selective vascular catheterization of the target vessel,
contrast injection(s), vessel measurement, roadmapping, postdilatation angiography, and
fluoroscopic guidance for the balloon dilatation)
61645  Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for
thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic
guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)
61650  Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for
thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging
guidance; initial vascular territory
61651  each additional vascular territory (List separately in addition to code for primary
procedure)
(Do not report 61650 or 61651 in conjunction with 36221, 36222, 36223, 36224, 36225,
36226, 61640, 61641, 61642, 61645 for the same vascular territory)
(Do not report 61650 or 61651 in conjunction with 96420, 96422, 96423, 96425 for the same
vascular territory)

**SURGERY FOR ANEURYSM, ARTERIOVENOUS MALFORMATION OR VASCULAR DISEASE**

Includes craniotomy when appropriate for procedure.
61680  Surgery of intracranial arteriovenous malformation; supratentorial, simple
61682  supratentorial, complex
61684  infratentorial, simple
61686  infratentorial, complex
61690  dural, simple
61692  dural, complex
61697  Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation
61698  vertebrobasilar circulation
(61697, 61698 involve aneurysms that are larger than 15 mm or with calcification of the aneurysm neck, or with incorporation of normal vessels into the aneurysm neck, or a procedure requiring temporary vessel occlusion, trapping or cardiopulmonary bypass to successfully treat the aneurysm)

61700 Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation  
61702 vertebrobasilar circulation  
61703 Surgery of intracranial aneurysm, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type)  
61705 Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery by intracranial electrothrombosis  
61710 by intra-arterial embolization, injection procedure, or balloon catheter  
61711 Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical) arteries

**STEREOTAXIS**

Coverage for 61781-61783 Stereotactic Computer-Assisted Volumetric (Navigational) Procedures is allowed only under the following conditions:

Procedure to be performed as a pre-surgical assessment and/or intraoperative assessment, in preparation for, and execution of planned craniotomy (CPT codes 61304-61576), along with a diagnosis of arteriovenous malformation of brain, malignant or benign neoplasm of the brain, or intractable epilepsy.

61720 Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus  
61735 subcortical structure(s) other than globus pallidus or thalamus  
61750 Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance  
61760 Stereotactic implantation of depth electrodes into the cerebrum for long term seizure monitoring  
61770 Stereotactic localization, including burr hole(s); with insertion of catheter(s) or probe(s) for placement of radiation source  
61781 Stereotactic computer-assisted ( navigational) procedure; cranial, intradural (List separately in addition to primary procedure)  
61782 cranial, extradural (List separately in addition to primary procedure)  
61783 spinal (List separately in addition to primary procedure)  
61790 Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); gasserian ganglion  
61791 trigeminal medullary tract

**STEREOTACTIC RADIOSURGERY (CRANIAL)**

61796 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion
(Do not report 61796 more than once per course of treatment)
(Do not report 61796 in conjunction with 61798)

61797  each additional cranial lesion, simple
    (List separately in addition to primary procedure)
    (Use 61797 in conjunction with 61796, 61798)
    (For each course of treatment, 61797 and 61799 may be reported no more than once per lesion. Do not report any combination of 61797 and 61799 more than 4 times for entire course of treatment regardless of number of lesions treated)

61798  1 complex cranial lesion
    (Do not report 61798 more than once per course of treatment)
    (Do not report 61798 in conjunction with 61796)

61799  each additional cranial lesion, complex
    (List separately in addition to primary procedure)
    (Use 61799 in conjunction with 61798)
    (For each course of treatment, 61797 and 61799 may be reported no more than once per lesion. Do not report any combination of 61797 and 61799 more than 4 times for entire course of treatment regardless of number of lesions treated)

61800  Application of stereotactic headframe for stereotactic radiosurgery
    (List separately in addition to primary procedure)
    (Use 61800 in conjunction with 61796, 61798)

**NEUROSTIMULATORS (INTRACRANIAL)**

Codes 61850-61888 apply to both simple and complex neurostimulators. For initial or subsequent electronic analysis and programming of neurostimulator pulse generators, see codes 95970-95975.

Microelectrode recording, when performed by the operating surgeon in association with implantation of neurostimulator electrode arrays, is an inclusive service and should not be reported separately. If another physician participates in neurophysiological mapping during a deep brain stimulator implantation procedure, this service may be reported by the other physician with codes 95961-95962.

61850  Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical
61860  Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral; cortical
61863  Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array
61864  each additional array
    (List separately in addition to primary procedure)
    (Use 61864 in conjunction with 61863)
61867  Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array
61868  each additional array
    (List separately in addition to primary procedure)
    (Use 61868 in conjunction with 61867)
61870 Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical
61880 Revision or removal of intracranial neurostimulator electrodes
61885 Incision or replacement of cranial neurostimulator pulse generator or receiver, direct or
inductive coupling; with connection to a single electrode array
61886 with connection to two or more electrode arrays
61888 Revision or removal of cranial neurostimulator pulse generator or receiver
(Do not report 61888 in conjunction with 61885 or 61886 for the same pulse generator)

**REPAIR**

62000 Elevation of depressed skull fracture; simple, extradural
62005 compound or comminuted, extradural
62010 with repair of dura and/or debridement of brain
62100 Craniotomy for repair of dural/cerebrospinal fluid leak, including surgery for
rhinorrhea/otorrhea
62115 Reduction of craniomegalic skull (eg, treated hydrocephalus); not requiring bone grafts or cranioplasty
62117 requiring craniotomy and reconstruction with or without bone graft
(includes obtaining grafts)
62120 Repair of encephalocele, skull vault, including cranioplasty
62121 Craniotomy for repair of encephalocele, skull base
62140 Cranioplasty for skull defect; up to 5 cm diameter
62141 larger than 5 cm diameter
62142 Removal of bone flap or prosthetic plate of skull
62143 Replacement of bone flap or prosthetic plate of skull
62145 Cranioplasty for skull defect with reparative brain surgery
62146 Cranioplasty with autograft (includes obtaining bone grafts); up to 5 cm diameter
62147 larger than 5 cm diameter
62148 Incision and retrieval of subcutaneous cranial bone graft for cranioplasty
(List separately in addition to primary procedure)
(Use 62148 in conjunction with codes 62140-62147)

**NEUROENDOSCOPY**

Surgical endoscopy always includes diagnostic endoscopy.

62160 Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and
attachment to shunt system or external drainage
(List separately in addition to primary procedure)
(Use 62160 only in conjunction with codes 61107, 61210, 62220, 62223, 62225 or 62230)
62161 Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum
pellucidum or intraventricular cysts (including placement, replacement, or removal of
ventricular catheter)
62162 with fenestration or excision of colloid cyst, including placement of external ventricular
catheter for drainage
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 trans-sphenoidal approach

CEREBROSPINAL FLUID (CSF) SHUNT

(For codes 62220, 62223, 62225, 62230, 62258, for intracranial neuroendoscopic ventricular catheter placement, use 62160)

62180 Ventriculocisternostomy (Torkildsen type operation)
62190 Creation of shunt; subarachnoid/subdural-atrial, -jugular, -auricular
62192 subarachnoid/subdural-peritoneal, -pleural, -other terminus
62194 Replacement or irrigation, subarachnoid/subdural catheter
62200 Ventriculocisternostomy, third ventricle
62201 stereotactic, neuroendoscopic method
62220 Creation of shunt; ventriculo-atrial, -jugular, -auricular
62223 ventriculo-peritoneal, -pleural, -other terminus
62225 Replacement or irrigation, ventricular catheter
62230 Replacement or revision of cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system
62252 Reprogramming of programmable cerebrospinal fluid shunt
62256 Removal of complete cerebrospinal fluid shunt system; without replacement
62258 with replacement by similar or other shunt at same operation

SPINE AND SPINAL CORD

INJECTION, DRAINAGE OR ASPIRATION

Injection of contrast during fluoroscopic guidance and localization is an inclusive component of codes 62263-62264, 62267, 62270-62273, 62280-62282. Fluoroscopic guidance and localization is reported by code 77003, unless a formal contrast study (myelography, epidurography, or arthrography) is performed, in which case the use of fluoroscopy is included in the supervision and interpretation codes.

Code 62263 describes a catheter-based treatment involving targeted injection of various substances (eg, hypertonic saline, steroid, anesthetic) via an indwelling epidural catheter. Code 62263 includes percutaneous insertion and removal of an epidural catheter (remaining in place over a several-day period), for the administration of multiple injections of a neurolytic agent(s) performed during serial treatment sessions (ie, spanning two or more treatment days). If required, adhesions or scarring may also be lysed by mechanical means. Code 62263 is NOT reported for each adhesiolysis treatment, but should be reported ONCE to describe the entire series of injections/infusions spanning two or more treatment days.

Code 62264 describes multiple adhesiolysis treatment sessions performed on the same day. Adhesions or scarring may be lysed by injections of neurolytic agent(s). If required, adhesions or scarring may also be lysed mechanically using a percutaneously-deployed catheter.

Codes 62263 and 62264 include the procedure of injections of contrast for epidurography (72275) and fluoroscopic guidance and localization (77003) during initial or subsequent sessions.
62263 Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days

62264 1 day

(Do not report 62264 with 62263)

(62263 and 62264 include codes 72275 and 77003)

62267 Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes

(Do not report 62267 in conjunction with 20225, 62287, 62290, 62291)

62268 Percutaneous aspiration, spinal cord cyst or syrinx

62269 Biopsy of spinal cord, percutaneous needle

62270 Spinal puncture, lumbar, diagnostic

62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)

62273 Injection, epidural, of blood or clot patch

62280 Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions) with or without other therapeutic substance; subarachnoid

62281 epidural, cervical or thoracic

62282 epidural, lumbar, sacral (caudal)

62284 Injection procedure for myelography and/or computed tomography, lumbar

(other than C1-C2 and posterior fossa)

62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar

62290 Injection procedure for discography, each level; lumbar

62291 cervical or thoracic

62292 Injection procedure for chemonucleolysis, including discography, intervertebral disk, single or multiple levels, lumbar

62294 Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal

62302 Myelography via lumbar injection, including radiological supervision and interpretation; cervical

62303 thoracic

62304 lumbosacral

62305 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/ cervical, lumbar/thoracic/cervical)

62320 Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

62321 with imaging guidance (ie, fluoroscopy or CT)

62322 Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance

62323 with imaging guidance (ie, fluoroscopy or CT)
62324  Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

62325  with imaging guidance (ie, fluoroscopy or CT)

62326  Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance

62327  with imaging guidance (ie, fluoroscopy or CT)

**CATHETER IMPLANTATION**

62350  Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir infusion pump; without laminectomy

62351  with laminectomy

62355  Removal of previously implanted intrathecal or epidural catheter

**RESERVOIR/PUMP IMPLANTATION**

62360  Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir

62361  nonprogrammable pump

62362  programmable pump, including preparation of pump, with or without programming

62365  Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion

62367  Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill

62368  with reprogramming

62370  with reprogramming and refill (requiring skill of a physician or other qualified health care professional)

(Do not report 62367-62370 in conjunction with 95900, 95991)

**POSTERIOR EXTRADURAL LAMINOTOMY OR LAMINECTOMY FOR EXPLORATION/DECOMPRESSION OF NEURAL ELEMENTS OR EXCISION OF HERNIATED INTERVERTEBRAL DISKS**

(For bilateral procedure report 63020, 63030, 63035, 63040, 63042, 63043, 63044 with modifier 50)

63001  Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), one or two vertebral segments; cervical

63003  thoracic

63005  lumbar, except for spondylolisthesis
63011  sacral
63012  Laminectomy with removal of abnormal facets and/or pars inter-articularis with
decompression of cauda equina and nerve roots for spondylolisthesis, lumbar
(Gill type procedure)
63015  Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina,
without facetectomy, foraminotomy or discectomy, (eg. spinal stenosis), more than 2
vertebral segments; cervical
63016    thoracic
63017    lumbar
63020  Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial
facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63030    1 interspace, lumbar
63035    each additional interspace, cervical or lumbar
(List separately in addition to primary procedure)
(Use 63035 in conjunction with 63020-63030)
63040  Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial
facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration,
single interspace; cervical
63042    lumbar
63043    each additional cervical interspace
(List separately in addition to primary procedure)
(Use 63043 in conjunction with 63040)
63044    each additional lumbar interspace
(List separately in addition to primary procedure)
(Use 63044 in conjunction with code 63042)
63045  Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of
spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single
vertebral segment; cervical
63046    thoracic
63047    lumbar
63048    each additional segment, cervical thoracic or lumbar
(List separately in addition to primary procedure)
(Use 63048 in conjunction with codes 63045-63047)
63050  Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral
segments;
63051    with reconstruction of the posterior bony elements (including the application of bridging
bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when
performed)
(Do not report 63050 or 63051 in conjunction with 22600, 22614, 22840-22842, 63001,
63015, 63045, 63048, 63295 for the same vertebral segment(s))

TRANSPEDICULAR OR COSTOVERTEBRAL APPROACH FOR POSTEROLATERAL
EXTRADURAL EXPLORATION/DECOMPRESSION
63055 Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disk), single segment; thoracic
63056 lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disk)
63057 each additional segment, thoracic or lumbar
(List separately in addition to primary procedure)
(Use 63057 in conjunction with codes 63055, 63056)
63064 Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic; single segment
63066 each additional segment
(List separately in addition to primary procedure)
(Use 63066 in conjunction with code 63064)

ANTERIOR OR ANTEROLATERAL APPROACH FOR EXTRADURAL EXPLORATION/DECOMPRESSION

For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of spinal cord exploration/decompression operation, append modifier -62 to the procedure code (and any associated add-on codes for that procedure code as long as both surgeons continue to work together as primary surgeons). One surgeon should file one claim line representing the procedure performed by the two surgeons.

In this situation, modifier -62 may be appended to the definitive procedure code(s) 63075, 63077, 63081, 63085, 63087, 63090 and, as appropriate, to associated additional interspace add-on code(s) 63076, 63078 or additional segment add-on code(s) 63082, 63086, 63088, 63091 as long as both surgeons continue to work together as primary surgeons.

63075 Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
63076 cervical, each additional interspace
(List separately in addition to primary procedure)
(Use 63076 in conjunction with 63075)
63077 thoracic, single interspace
63078 thoracic, each additional interspace
(List separately in addition to primary procedure)
(Use 63078 in conjunction with 63077)
63081 Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082 cervical, each additional segment
(List separately in addition to primary procedure)
(Use 63082 in conjunction with 63081)
63085 Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment
63086 thoracic, each additional segment
(List separately in addition to primary procedure)
(Use 63086 in conjunction with 63085)
63087  Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment

63088  each additional segment
   (List separately in addition to primary procedure)
   (Use 63088 in conjunction with 63087)

63090  Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment

63091  each additional segment
   (List separately in addition to primary procedure)
   (Use 63091 in conjunction with 63090)
   (Procedures 63081-63091 include discectomy above and/or below vertebral segment)

**LATERAL EXTRACAVITARY APPROACH FOR EXTRADURAL EXPLORATION/DECOMPRESSION**

63101  Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment

63102  lumbar, single segment

63103  thoracic or lumbar, each additional segment
   (List separately in addition to primary procedure)
   (Use 63103 in conjunction with 63101 and 63102)

**INCISION**

63170  Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic or thoracolumbar

63172  Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid space

63173  to peritoneal or pleural space

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)

63194  Laminectomy with cordotomy, with section of one spinothalamic tract, one stage; cervical

63195  thoracic

63196  Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage; cervical

63197  thoracic

63198  Laminectomy with cordotomy, with section of both spinothalamic tracts, two stages within 14 days; cervical

63199  thoracic

63200  Laminectomy, with release of tethered spinal cord, lumbar
EXCISION BY LAMINECTONY OF LESION OTHER THAN HERNIATED DISK

63250 Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical
63251 thoracic
63252 thoracolumbar
63265 Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
63266 thoracic
63267 lumbar
63268 sacral
63270 Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical
63271 thoracic
63272 lumbar
63273 sacral
63275 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical
63276 extradural, thoracic
63277 extradural, lumbar
63278 extradural, sacral
63280 intradural, extramedullary, cervical
63281 intradural, extramedullary, thoracic
63282 intradural, extramedullary, lumbar
63283 intradural, sacral
63285 intradural, intramedullary, cervical
63286 intradural, intramedullary, thoracic
63287 intradural, intramedullary, thoracolumbar
63290 combined extradural-intradural lesion, any level
63295 Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure
(List separately in addition to primary procedure)
(Use 63295 in conjunction with 63172, 63173, 63185, 63190, 63200-63290)
(Do not report 63295 in conjunction with 22590-22614, 22840-22844, 63050, 63051 for the
same vertebral segment(s))

EXCISION, ANTERIOR OR ANTEROLATERAL APPROACH, INTRASPINAL LESION

For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of an anterior approach for an intraspinal excision, append modifier -62 to the single definitive procedure code. One surgeon should file one claim line representing the procedure performed by the two surgeons. In this situation, modifier 62 may be appended to the definitive procedure code(s) 63300-63307 and, as appropriate, to the associated additional segment add-on code 63308 as long as both surgeons continue to work together as primary surgeons.

63300 Vertebral corpectomy (vertebral body resection), partial or complete for excision of intraspinal lesion, single segment; extradural, cervical
63301 extradural, thoracic by transthoracic approach
63302 extradural, thoracic by thoracolumbar approach
63303 extradural, lumbar or sacral by transperitoneal or retroperitoneal approach
63304  intradural, cervical
63305  intradural, thoracic by transthoracic approach
63306  intradural, thoracic by thoracolumbar approach
63307  intradural, lumbar or sacral by transperitoneal or retroperitoneal approach
63308  each additional segment
   (List separately in addition to codes for single segment)
   (Use in conjunction with 63300-63307)

STEREOTAXIS

63600  Creation of lesion of spinal cord by stereotactic method, percutaneous, any modality
   (including stimulation and/or recording)
63610  Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by
   other surgery

STEREOTACTIC RADIOSURGERY (SPINAL)

63620  Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion
   (Do not report 63620 more than once per course of treatment)
63621  each additional spinal lesion
   (List separately in addition to primary procedure)
   (Report 63621 in conjunction with 63620)
   (For each course of treatment, 63621 may be reported no more than once per lesion.
    Do not report 63621 more than 2 times for entire course of treatment regardless of
    number of lesions treated)

NEUROSTIMULATORS (SPINAL)

Codes 63650-63688 apply to both simple and complex neurostimulators. For initial or subsequent
electronic analysis and programming of neurostimulator pulse generators, see codes 95970-95975.

Codes 63650, 63655, and 63661-63664 describe the operative placement, revision, or removal of the
spinal neurostimulator system components to provide spinal electrical stimulation. A neurostimulator
system includes an implanted neurostimulator, external controller, extension, and collection of
contacts. Multiple contacts or electrodes (4 or more) provide the actual electrical stimulation in the
epidural space.

For percutaneously placed neurostimulator systems (63650, 63661, 63663) the contacts are on a
catheter-like lead. An array defines the collection of contacts that are on one catheter.

For systems placed via an open surgical exposure (63655, 63662, 63664) the contacts are on a plate
or paddle-shaped surface.

63650  Percutaneous implantation of neurostimulator electrode array, epidural
63655  Laminectomy for implantation of neurostimulator electrodes plate/paddle, epidural
63661  Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy,
      when performed
63662  Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed

63663  Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
(Do not report 63663 in conjunction with 63661, 63662 for the same spinal level)

63664  Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
(Do not report 63664 in conjunction with 63661, 63662 for the same spinal level)

63685  Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
(Do not report 63685 in conjunction with 63688 for the same pulse generator or receiver)

63688  Revision or removal of implanted spinal neurostimulator pulse generator or receiver

REPAIR
(Do not use modifier –63 in conjunction with 63700-63706)

63700  Repair of meningocele; less than 5 cm diameter
63702  larger than 5 cm diameter
63704  Repair of myelomeningocele; less than 5 cm diameter
63706  larger than 5 cm diameter
63707  Repair of dural/cerebrospinal fluid leak, not requiring laminectomy
63709  Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy
63710  Dural graft, spinal

SHUNT, SPINAL CSF

63740  Creation of shunt, lumbar, subarachnoid- peritoneal, -pleural, or other; including laminectomy
63741  percutaneous, not requiring laminectomy
63744  Replacement, irrigation or revision of lumbosubarachnoid shunt
63746  Removal of entire lumbosubarachnoid shunt system without replacement

EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM

INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC:

SOMATIC NERVES

64400  Injection, anesthetic agent; trigeminal nerve, any division or branch
64402  facial nerve
64405  greater occipital nerve
64408  vagus nerve
64410  phrenic nerve
64413  cervical plexus
64415  brachial plexus, single
64416  brachial plexus, continuous infusion by catheter (including catheter placement)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64417</td>
<td>axillary nerve</td>
</tr>
<tr>
<td>64418</td>
<td>suprascapular nerve</td>
</tr>
<tr>
<td>64420</td>
<td>intercostal nerve, single</td>
</tr>
<tr>
<td>64421</td>
<td>intercostal nerves, multiple, regional block</td>
</tr>
<tr>
<td>64425</td>
<td>ilioinguinal, iliohypogastric nerves</td>
</tr>
<tr>
<td>64430</td>
<td>pudendal nerve</td>
</tr>
<tr>
<td>64435</td>
<td>paracervical (uterine) nerve</td>
</tr>
<tr>
<td>64445</td>
<td>sciatic nerve, single</td>
</tr>
<tr>
<td>64446</td>
<td>sciatic nerve, continuous infusion by catheter, (including catheter placement)</td>
</tr>
<tr>
<td>64447</td>
<td>femoral nerve, single</td>
</tr>
<tr>
<td>64448</td>
<td>femoral nerve, continuous infusion by catheter, (including catheter placement)</td>
</tr>
<tr>
<td>64449</td>
<td>lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)</td>
</tr>
<tr>
<td>64450</td>
<td>other peripheral nerve or branch</td>
</tr>
<tr>
<td>64455</td>
<td>Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma) (Do not report 64455 in conjunction with 64632)</td>
</tr>
<tr>
<td>64479</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level</td>
</tr>
<tr>
<td>64480</td>
<td>cervical or thoracic, each additional level (List separately in addition to primary procedure) (Use 64480 in conjunction with 64479)</td>
</tr>
<tr>
<td>64483</td>
<td>lumbar or sacral, single level</td>
</tr>
<tr>
<td>64484</td>
<td>lumbar or sacral, each additional level (List separately in addition to primary procedure) (Use 64484 in conjunction with 64483)</td>
</tr>
<tr>
<td>64461</td>
<td>Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed) (Report Required)</td>
</tr>
<tr>
<td>64462</td>
<td>second and any additional injection site(s) (includes imaging guidance when performed) (List separately in addition to code for primary procedure) (Report required) (Do not report 64462 more than once per day)</td>
</tr>
<tr>
<td>64463</td>
<td>continuous infusion by catheter (includes imaging guidance when performed) (Report required)</td>
</tr>
<tr>
<td>64486</td>
<td>Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)</td>
</tr>
<tr>
<td>64487</td>
<td>by continuous infusion(s) (includes imaging guidance, when performed)</td>
</tr>
<tr>
<td>64488</td>
<td>Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)</td>
</tr>
<tr>
<td>64489</td>
<td>by continuous infusions (includes imaging guidance, when performed)</td>
</tr>
</tbody>
</table>
64490  Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), cervical or thoracic; single level
64491  second level
   (List separately in addition to primary procedure)
64492  third and any additional level(s)
   (List separately in addition to primary procedure)
64493  lumbar or sacral; single level
64494  second level
   (List separately in addition to primary procedure)
64495  third and any additional level(s)
   (List separately in addition to primary procedure)
   (Do not report 64495 more than once per day)

SYMPATHETIC NERVES

64505  Injection, anesthetic agent; sphenopalatine ganglion
64510  stellate ganglion (cervical sympathetic)
64517  superior hypogastric plexus
64520  lumbar or thoracic (paravertebral sympathetic)
64530  celiac plexus, with or without radiologic monitoring

NEUROSTIMULATORS (PERIPHERAL NERVE)

Codes 64553-64595 apply to both simple and complex neurostimulators. For initial or subsequent electronic analysis and programming of neurostimulator pulse generators, see codes 95970-95975.

64553  Percutaneous implantation of neurostimulator electrode array; cranial nerve
64555  peripheral nerve (excludes sacral nerve)
   (Do not report 64555 in conjunction with 64566)
64561  sacral nerve (transforaminal placement) including image guidance, if performed
64566  Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming
   (Do not report 64566 in conjunction with 64555, 95970-95972)
64568  Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
   (Do not report 64568 in conjunction with 61885, 61886, 64570)
64569  Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
   (Do not report 64569 in conjunction with 64570 or 61888)
64570  Removal of cranial nerve (eg. vagus nerve) neurostimulator electrode array and pulse generator
   (Do not report 64570 in conjunction with 61888)
64575  Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64580  neuromuscular
64581  sacral nerve (transforaminal placement)
64585  Revision or removal of peripheral neurostimulator electrode array
64590  Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
(Do not report 64590 in conjunction with 64595)
64595  Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver

DESTRUCTION BY NEUROLYTIC AGENT (EG, CHEMICAL, THERMAL, ELECTRICAL, 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
64611  Chemodenervation of parotid and submandibular salivary glands, bilateral
64612  Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)
64615  muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
64616  neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)
64617  larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed
64620  Destruction by neurolytic agent; intercostal nerve
64630  Destruction by neurolytic agent; pudendal nerve
64632  plantar common digital nerve
(Do not report 64632 in conjunction with 64455)
64633  Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634  cervical or thoracic, each additional facet joint
(List separately in addition to primary procedure)
(Use 64634 in conjunction with 64633)
64635  lumbar or sacral, single facet joint
64636  lumbar or sacral, each additional facet joint
(List separately in addition to primary procedure)
(Use 64636 in conjunction with 64635)
(Do not report 64633-64636 in conjunction with 77003, 77012)
(For bilateral procedure, report 64633-64636 with modifier 50)
64640  other peripheral nerve or branch
64642  Chemodenervation of one extremity; 1-4 muscle(s)
64643  each additional extremity; 1-4 muscle(s) (List separately in addition to code for primary procedure)
64644  Chemodenervation of one extremity; 5 or more muscle(s)
64645  each additional extremity; 5 or more muscle(s) (List separately in addition to code for primary procedure)
64646  Chemodenervation of trunk muscle(s); 1-5 muscle(s)
64647  6 or more muscle(s)

SYMPATHETIC NERVES

64650  Chemodenervation of eccrine glands; both axillae
64653  other area(s) (eg, scalp, face, neck), per day
64680  Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus
64681  superior hypogastric plexus

NEUROPLASTY (EXPLORATION, NEUROLYSIS OR NERVE DECOMPRESSION)

Neuroplasty is the decompression or freeing of intact nerve from scar tissue, including external neurolysis and/or transposition.

64702  Neuroplasty; digital, one or both, same digit
64704  nerve of hand or foot
64708  Neuroplasty, major peripheral nerve, arm or leg, open; other than specified
64712  sciatic nerve
64713  brachial plexus
64714  lumbar plexus
64716  Neuroplasty and/or transposition; cranial nerve (specify)
64718  ulnar nerve at elbow
64719  ulnar nerve at wrist
64721  median nerve at carpal tunnel
64722  Decompression; unspecified nerve(s) (specify)
64726  plantar digital nerve
64727  Internal neurolysis, requiring use of operating microscope
   (List separately in addition to code for neuroplasty)
   (Neuroplasty includes external neurolysis)

TRANSECTION OR AVULSION

64732  Transection or avulsion of; supraorbital nerve
64734  infraorbital nerve
64736  mental nerve
64738  inferior alveolar nerve by osteotomy
64740  lingual nerve
64742  facial nerve, differential or complete
64744  greater occipital nerve
64746  phrenic nerve
64755 vagus nerve limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotony, parietal cell vagotomy, supra- or highly selective vagotomy)
64760 vagus nerve (vagotomy), abdominal
64763 Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy
64766 Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy
64771 Transection or avulsion of other cranial nerve, extradural
   (For procedures 64763, 64766, for bilateral procedure, use modifier -50)
64772 Transection or avulsion of other spinal nerve, extradural

EXCISION

SOMATIC NERVES

64774 Excision of neuroma; cutaneous nerve, surgically identifiable
64776 digital nerve, one or both, same digit
64778 digital nerve, each additional digit
   (List separately in addition to primary procedure)
   (Use 64778 in conjunction with 64776)
64782 hand or foot, except digital nerve
64783 hand or foot, each additional nerve, except same digit
   (List separately in addition to primary procedure)
   (Use 64783 in conjunction with 64782)
64784 major peripheral nerve, except sciatic
64786 sciatic nerve
64787 Implantation of nerve end into bone or muscle
   (List separately in addition to neuroma excision)
   (Use 64787 in conjunction with 64774-64786)
64788 Excision of neurofibroma or neurolemmoma; cutaneous nerve
64790 major peripheral nerve
64792 extensive (including malignant type)
64795 Biopsy of nerve

SYMPATHETIC NERVES

(For procedures 64802, 64804, 64809, 64818 for bilateral procedure, use modifier -50)

64802 Sympathectomy, cervical
64804 cervicothoracic
64809 thoracolumbar
64818 lumbar
64820 digital arteries, each digit
64821 radial artery
64822 ulnar artery
64823 superficial palmar arch

NEURORRHAPHY

64831 Suture of digital nerve, hand or foot; one nerve
64832 each additional digital nerve
  (List separately in addition to primary procedure)
  (Use 64832 in conjunction with 64831)
64834 Suture of one nerve; hand or foot, common sensory nerve
64835 median motor thenar
64836 ulnar motor
64837 Suture of each additional nerve, hand or foot
  (List separately in addition to primary procedure)
  (Use 64837 in conjunction with 64834-64836)
64840 Suture of posterior tibial nerve
64856 Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64857 without transposition
64858 Suture of sciatic nerve
64859 Suture of each additional major peripheral nerve
  (List separately in addition to primary procedure)
  (Use 64859 in conjunction with 64856, 64857)
64861 Suture of; brachial plexus
64862 lumbar plexus
64864 Suture of facial nerve; extracranial
64865 infratemporal, with or without grafting
64866 Anastomosis; facial-spinal accessory
64868 facial-hypoglossal
64872 Suture of nerve; requiring secondary or delayed suture
  (List separately in addition to primary neurorrhaphy)
  requiring extensive mobilization, or transposition of nerve
  (List separately in addition to code for nerve suture)
  requiring shortening of bone of extremity
  (List separately in addition to code for nerve suture)
  (Use 64872, 64874, 64876 in conjunction with 64831-64865)

NEURORRHAPHY WITH NERVE GRAFT, VEIN GRAFT, OR CONDUIT

64885 Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length
64886 more than 4 cm in length
64890 Nerve graft (includes obtaining graft), single strand hand or foot; up to 4 cm length
64891 more than 4 cm length
64892 Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64893 more than 4 cm length
64895 Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length
64896 more than 4 cm length
64897 Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length
64898 more than 4 cm length
64901 Nerve graft, each additional nerve; single strand
  (List separately in addition to primary procedure)
  (Use 64901 in conjunction with 64885-64893)
64902 multiple strands (cable)
(List separately in addition to primary procedure)
(Use 64902 in conjunction with 64885, 64886, 64895-64898)

64905 Nerve pedicle transfer; first stage
64907 second stage
64910 Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve
64911 with autogenous vein graft (includes harvest of vein graft), each nerve

OTHER PROCEDURES
64999 Unlisted procedure, nervous system

EYE AND OCULAR ADNEXA
(For diagnostic and treatment ophthalmological services, see MEDICINE, Ophthalmology, and 92002 et seq)

EYEBALL

REMOVAL OF EYE
65091 Evisceration of ocular contents; without implant
65093 with implant
65101 Enucleation of eye; without implant
65103 with implant, muscles not attached to implant
65105 with implant, muscles attached to implant
65110 Exenteration of orbit (does not include skin graft), removal of orbital contents; only
65112 with therapeutic removal of bone
65114 with muscle or myocutaneous flap

SECONDARY IMPLANT(S) PROCEDURES
An ocular implant is an implant inside muscular cone; an orbital implant is an implant outside muscular cone.

65125 Modification of ocular implant with placement or replacement of pegs (eg, drilling receptacle for prosthesis appendage) (separate procedure)
65130 Insertion of ocular implant secondary; after evisceration, in scleral shell
65135 after enucleation, muscles not attached to implant
65140 after enucleation, muscles attached to implant
65150 Reinsertion of ocular implant; with or without conjunctival graft
65155 with use of foreign material for reinforcement and/or attachment of muscles to implant
65175 Removal of ocular implant

REMOVAL OF FOREIGN BODY
65205 Removal of foreign body, external eye; conjunctival superficial
65210 conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
65220 corneal, without slit lamp
65222  corneal, with slit lamp
65235  Removal of foreign body, intraocular; from anterior chamber of eye or lens
65260  from posterior segment, magnetic extraction, anterior or posterior route
65265  from posterior segment, nonmagnetic extraction

REPAIR OF LACERATION
65270  Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure
65272  conjunctiva, by mobilization and rearrangement, without hospitalization
65273  conjunctiva, by mobilization and rearrangement, with hospitalization
65275  cornea, nonperforating, with or without removal foreign body
65280  cornea and/or sclera, perforating, not involving uveal tissue
65285  cornea and/or sclera, perforating, with reposition or resection of uveal tissue
65286  application of tissue glue, wounds of cornea and/or sclera
65290  Repair of wound, extraocular muscle, tendon and/or Tenon's capsule

ANTERIOR SEGMENT
CORNEA
EXCISION
65400  Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium
65410  Biopsy of cornea
65420  Excision or transposition of pterygium; without graft
65426  with graft

REMOVAL OR DESTRUCTION
65430  Scraping of cornea, diagnostic, for smear and/or culture
65435  Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)
65436  with application of chelating agent, eg, EDTA
65450  Destruction of lesion of cornea by cryotherapy, photocoagulation or thermocauterization
65600  Multiple punctures of anterior cornea (eg, for corneal erosion, tattoo)

KERATOPLASTY
Corneal transplant includes use of fresh or preserved grafts, and preparation of donor material. (Keratoplasty excludes refractive keratoplasty procedures 65760, 65765 and 65767)

65710  Keratoplasty (corneal transplant); anterior lamellar
65730  penetrating (except in aphakia or pseudophakia)
65750  penetrating (in aphakia)
65755  penetrating (in pseudophakia)
65766  endothelial

OTHER PROCEDURES
65778, 65779, 65780, 65781, 65782 are billable for patients with ocular surface deficiency, for those patients: who have sustained ocular burns and/or injuries OR; who have ocular complications secondary to Stevens-Johnson syndrome OR; who have undergone multiple surgeries or cryotherapies to the limbal region OR; who require these reconstructive procedures in addition to NYS Medicaid covered keratoplasty procedures OR; for whom medical management (lubricants, artificial tears, topical and systemic antibiotics, topical and systemic steroids, patches, etc.) has proven ineffective.

65760 Keratomileusis
65765 Keratophakia
65767 Epikeratoplasty
65770 Keratoprosthesis
65771 Radial keratotomy
65772 Corneal relaxing incision for correction of surgically induced astigmatism
65775 Corneal wedge resection for correction of surgically induced astigmatism
65778 Placement of amniotic membrane on the ocular surface; without sutures
65779 single layer, sutured
65780 Ocular surface reconstruction; amniotic membrane transplantation, multiple layers
65781 limbal stem allograft (eg, cadaveric or living donor)
65782 limbal conjunctival autograft (includes obtaining graft)

ANTERIOR CHAMBER

INCISION

65800 Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous
65810 with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection
65815 with removal of blood, with or without irrigation and/or air injection
65820 Goniotomy
(Do not report modifier -63 in conjunction with 65820)
(For use of ophthalmic endoscope with 65820, use 66990)
65850 Trabeculotomy ab externo
65855 Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)
65860 Severing adhesions of anterior segment, laser technique (separate procedure)
65865 Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); goniosynechiae
65870 anterior synechiae, except goniosynechiae
65875 posterior synechiae
(For use of ophthalmic endoscope with 65875, use 66990)
65880 corneovitreal adhesions

REMOVAL

65900 Removal of epithelial downgrowth, anterior chamber of eye
65920 Removal of implanted material, anterior segment of eye
(For use of ophthalmic endoscope with 65920, use 66990)

65930 Removal of blood clot, anterior segment of eye

INTRODUCTION

66020 Injection, anterior chamber of eye (separate procedure); air or liquid
66030 medication

ANTERIOR SCLERA

EXCISION

66130 Excision of lesion, sclera
66150 Fistulization of sclera for glaucoma; trephination with iridectomy
66155 thermocauterization with iridectomy
66160 sclerectomy with punch or scissors, with iridectomy
66170 trabeculectomy ab externo in absence of previous surgery
66172 trabeculectomy ab externo with scarring from previous ocular surgery or trauma
   (includes injection of antifibrotic agents)
66174 Transluminal dilation of aqueous outflow canal; without retention of device or stent
66175 with retention of device or stent

AQUEOUS SHUNT

66179 Aqueous shunt to extraocular equatorial plate reservoir, external
   approach; without graft
66180 with graft
66184 Revision of aqueous shunt to extraocular equatorial plate reservoir;
   without graft
66185 with graft

REPAIR OR REVISION

66225 Repair of scleral staphyloma with graft
66250 Revision or repair of operative wound of anterior segment, any type, early or late, major or
   minor procedure

IRIS, CILIARY BODY

INCISION

66500 Iridotomy by stab incision (separate procedure); except transfixion
66505 with transfixion as for iris bombe

EXCISION

66600 Iridectomy, with corneoscleral or corneal section; for removal of lesion
66605 with cyclectomy
66625 peripheral for glaucoma (separate procedure)
66630  sector for glaucoma (separate procedure)
66635  optical (separate procedure)

**REPAIR**

66680  Repair of iris, ciliary body (as for iridodialysis)
66682  Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture)

**DESTRUCTION**

66700  Ciliary body destruction; diathermy,
66710  cyclophotocoagulation, transscleral
66711  cyclophotocoagulation, endoscopic
   (Do not report 66711 in conjunction with 66990)
66720  cryotherapy
66740  cyclodialysis
66761  Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)
66762  Iridoplasty by photoocoagulation (one or more sessions) (eg, for improvement of vision for widening of anterior chamber angle)
66770  Destruction of cyst or lesion iris or ciliary body (nonexcisional procedure)

**LENS**

**INCISION**

66820  Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)
66821  laser surgery (eg, YAG laser) (one or more stages)
66825  Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)

**REMOVAL**

Lateral canthotomy, iridectomy, iridotomy, anterior capsulotomy, posterior capsulotomy, the use of viscoelastic agents, enzymatic zonulysis, use of other pharmacologic agents, and subconjunctival or sub-tenon injections are included as part of the code for the extraction of lens.

66830  Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
66840  Removal of lens material; aspiration technique, one or more stages
66850  phacofragmentation technique (mechanical or ultrasonic,)
   (eg, phacoemulsification), with aspiration
66852  pars plana approach, with or without vitrectomy
66920  intracapsular
66930  intracapsular, for dislocated lens
66940  extracapsular (other than 66840, 66850, 66852)
**INTRAOCULAR LENS PROCEDURES**

66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (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)

66985 Insertion of intraocular lens prosthesis (secondary implant) not associated with concurrent cataract removal
   (For use of ophthalmic endoscope with 66985, use 66990)

66986 Exchange of intraocular lens
   (For use of ophthalmic endoscope with 66986, use 66990)

**OTHER PROCEDURES**

66990 Use of ophthalmic endoscope
   (List separately in addition to primary procedure)
   (66990 may be used only with codes 65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041, 67042, 67043, 67113)

66999 Unlisted procedure, anterior segment, eye

**POSTERIOR SEGMENT**

**VITREOUS**

67005 Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal

67010 subtotal removal with mechanical vitrectomy

67015 Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)

67025 Injection of vitreous substitute, pars plana or limbal approach, (fluid-gas exchange), with or without aspiration (separate procedure)

67027 Implantation of intravitreal drug delivery system (eg, Ganciclovir implant), includes concomitant removal of vitreous

67028 Intravitreal injection of a pharmacologic agent (separate procedure)

67030 Discission of vitreous strands (without removal), pars plana approach

67031 Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)

67036 Vitrectomy, mechanical, pars plana approach;

67039 with focal endolaser photoagulation

67040 with endolaser panretinal photoagulation

67041 with removal of preretinal cellular membrane (eg, macular pucker)
67042  with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)

67043  with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation

**RETINA OR CHOROID**

**REPAIR**

(If diathermy, cryotherapy and/or photocoagulation are combined, report under principal modality used)

67101  Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy

67105  photocoagulation

67107  Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation and drainage of subretinal fluid

67108  with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique

67110  by injection of air or other gas (eg, pneumatic retinopexy)

67113  Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens

67115  Release of encircling material (posterior segment)

67120  Removal of implanted material, posterior segment; extraocular

67121  intraocular

**PROPHYLAXIS**

Codes 67141, 67145, 67208-67220, 67227, 67228, 67229 include treatment at one or more sessions that may occur at different encounters. These codes should be reported once during a defined treatment period.

Repetitive services. The services listed below are often performed in multiple sessions or groups of sessions. The methods of reporting vary.

The following descriptors are intended to include all sessions in a defined treatment period.

67141  Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy

67145  photocoagulation (laser or xenon arc)

**DESTRUCTION**
67208 Destruction of localized lesion of retina (eg, macular edema, tumors) one or more sessions; cryotherapy, diathermy
67210 photocoagulation
67218 radiation by implantation of source (includes removal of source)
67220 Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), one or more sessions
67221 photodynamic therapy (includes intravenous infusion)
67225 photodynamic therapy, second eye, at single session (List separately in addition to primary eye treatment) (Use 67225 in conjunction with code 67221)
67227 Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; cryotherapy, diathermy
67228 Treatment of extensive or progressive retinopathy, one or more sessions; (eg, diabetic retinopathy), photocoagulation
67229 preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy (For bilateral procedure, use modifier 50)

POSTERIOR SCLERAL

REPAIR
67250 Scleral reinforcement (separate procedure); without graft
67255 with graft

OTHER PROCEDURES
67299 Unlisted procedure, posterior segment

OCULAR ADNEXA

EXTRAOCULAR MUSCLES
(Use 67320, 67331, 67332, 67334 in conjunction with 67311-67318)
(Use 67335, 67340, in conjunction with 67311-67334)
(Use 67343 in conjunction with 67311-67340, when such procedures are performed other than on the affected muscle)
(For adjustable sutures, use 67335 in addition to codes 67311-67334 for primary procedure reflecting number of muscles operated on)
67311 Strabismus surgery, recession or resection procedure; one horizontal muscle
67312 two horizontal muscles
67314 one vertical muscle (excluding superior oblique)
67316 two or more vertical muscles (excluding superior oblique)
67318 Strabismus surgery, any procedure superior oblique muscle
67320 Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify)  
(List separately in addition to primary procedure)

67331 Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles  
(List separately in addition to primary procedure)

67332 Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy)  
(List separately in addition to primary procedure)

67334 Strabismus surgery by posterior fixation suture technique, with or without muscle recession  
(List separately in addition to primary procedure)

67335 Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s)  
(List separately in addition to code for specific strabismus surgery)

67340 Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s)  
(List separately in addition to primary procedure)

67343 Release of extensive scar tissue without detaching extraocular muscle (separate procedure)

67345 Chemodenervation of extraocular muscle

67346 Biopsy of extraocular muscle

OTHER PROCEDURES

67399 Unlisted procedure, extraocular muscle

ORBIT

EXPLORATION, EXCISION, DECOMPRESSSION

67400 Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy

67405 with drainage only

67412 with removal of lesion

67413 with removal of foreign body

67414 with removal of bone for decompression

67415 Fine needle aspiration of orbital contents

67420 Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion

67430 with removal of foreign body

67440 with drainage

67445 with removal of bone for decompression

67450 for exploration, with or without biopsy

OTHER PROCEDURES

67500 Retrobulbar injection; medication (separate procedure, does not include supply of medication)

67505 alcohol
67515 Injection of medication or other substance into Tenon’s capsule
67550 Orbital implant (implant outside muscle cone); insertion
67560 Orbital implant (implant outside muscle cone); removal or revision
67570 Optic nerve decompression (eg, incision or fenestration of optic nerve sheath)
67599 Unlisted procedure, orbit

**EYELIDS**

**INCISION**

67700 Blepharotomy, drainage of abscess, eyelid
67710 Severing of tarsorrhaphy
67715 Canthotomy (separate procedure)

**EXCISION, DESTRUCTION**

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

67800 Excision of chalazion; single
67801 multiple, same lid
67805 multiple, different lids
67808 under general anesthesia and/or requiring hospitalization, single or multiple
67810 Incisional biopsy of eyelid skin including lid margin
67820 Correction of trichiasis; epilation, by forceps only
67825 epilation by other than forceps (eg, by electrosurgery, cryotherapy, laser surgery)
67830 incision of lid margin
67835 incision of lid margin, with free mucous membrane graft
67840 Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure
67850 Destruction of lesion of lid margin (up to 1 cm)

**TARSORRHAPHY**

67875 Temporary closure of eyelids by suture (eg, Frost suture)
67880 Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;
67882 with transposition of tarsal plate

**REPAIR (BROW PTOSIS, BLEPHAROPTOSIS, LID RETRACTION, ECTROPION, ENTROPION)**

67900 Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901 Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902 frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903 (tarso) levator resection or advancement, internal approach
67904 (tarso) levator resection or advancement, external approach
67906 superior rectus technique with fascial sling (includes obtaining fascia)
67908 conjunctivo-tarso-Muller’s muscle-levator resection (Fasanella-Servat type)
67909 Reduction of overcorrection of ptosis
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>67911</td>
<td>Correction of lid retraction</td>
</tr>
<tr>
<td>67912</td>
<td>Correction of lagophthalmos, with implantation of upper eyelid lid load</td>
</tr>
<tr>
<td></td>
<td>(eg, gold weight)</td>
</tr>
<tr>
<td>67914</td>
<td>Repair of ectropion; suture</td>
</tr>
<tr>
<td>67915</td>
<td>thermocauterization</td>
</tr>
<tr>
<td>67916</td>
<td>excision tarsal wedge</td>
</tr>
<tr>
<td>67917</td>
<td>extensive (eg, tarsal strip operations)</td>
</tr>
<tr>
<td>67921</td>
<td>Repair of entropion; suture</td>
</tr>
<tr>
<td>67922</td>
<td>thermocauterization</td>
</tr>
<tr>
<td>67923</td>
<td>excision tarsal wedge</td>
</tr>
<tr>
<td>67924</td>
<td>extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)</td>
</tr>
</tbody>
</table>

**RECONSTRUCTION**

Codes for blepharoplasty involve more than skin (ie, involving lid margin, tarsus, and/or palpebral conjunctiva)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>67930</td>
<td>Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva, direct closure; partial</td>
</tr>
<tr>
<td></td>
<td>thickness</td>
</tr>
<tr>
<td>67935</td>
<td>full thickness</td>
</tr>
<tr>
<td>67938</td>
<td>Removal of embedded foreign body, eyelid</td>
</tr>
<tr>
<td>67950</td>
<td>Canthoplasty (reconstruction of canthus)</td>
</tr>
<tr>
<td>67961</td>
<td>Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include</td>
</tr>
<tr>
<td></td>
<td>preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one fourth of lid</td>
</tr>
<tr>
<td></td>
<td>margin</td>
</tr>
<tr>
<td>67966</td>
<td>over one fourth of lid margin</td>
</tr>
</tbody>
</table>
| 67971  | Reconstruction of eyelid, full thickness by transfer of tarsconjunctival 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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>67999</td>
<td>Unlisted procedure, eyelids</td>
</tr>
</tbody>
</table>

**CONJUNCTIVA**

**INCISION AND DRAINAGE**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>68020</td>
<td>Incision of conjunctiva, drainage of cyst</td>
</tr>
<tr>
<td>68040</td>
<td>Expression of conjunctival follicles (eg, for trachoma)</td>
</tr>
</tbody>
</table>

**EXCISION AND/OR DESTRUCTION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>68100</td>
<td>Biopsy of conjunctiva</td>
</tr>
<tr>
<td>68110</td>
<td>Excision of lesion, conjunctiva; up to 1 cm</td>
</tr>
<tr>
<td>68115</td>
<td>over 1 cm</td>
</tr>
<tr>
<td>68130</td>
<td>with adjacent sclera</td>
</tr>
</tbody>
</table>
68135  Destruction of lesion, conjunctiva

INJECTION
68200  Subconjunctival injection

CONJUNCTIVOPLASTY
68320  Conjunctivoplasty; with conjunctival graft or extensive rearrangement
68325    with buccal mucous membrane graft (includes obtaining graft)
68326  Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive
        rearrangement
68328    with buccal mucous membrane graft (includes obtaining graft)
68330  Repair of symblepharon; conjunctivoplasty, without graft
68335    with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)
68340    division of symblepharon with or without insertion of conformer or contact lens

OTHER PROCEDURES
68360  Conjunctival flap; bridge or partial (separate procedure)
68362    total (such as Gunderson thin flap or purse string flap)
68399  Unlisted procedure, conjunctiva

LACRIMAL SYSTEM
INCISION
68400  Incision, drainage of lacrimal gland
68420  Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy)
68440  Snip incision of lacrimal punctum

EXCISION
68500  Excision of lacrimal gland (dacryoadenectomy), except for tumor; total
68505    partial
68510  Biopsy of lacrimal gland
68520  Excision of lacrimal sac (dacryocystectomy)
68525  Biopsy of lacrimal sac
68530  Removal of foreign body or dacryolith, lacrimal passages
68540  Excision of lacrimal gland tumor; frontal approach
68550    involving osteotomy

REPAIR
68700  Plastic repair of canaliculi
68705  Correction of everted punctum, cautery
68720  Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)
68745  Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube
68750    with insertion of tube or stent
68760  Closure of lacrimal punctum; by thermocauterization, ligation, or laser surgery
68761  by plug, each
68770  Closure of lacrimal fistula (separate procedure)

PROBING AND/OR RELATED PROCEDURES
(For codes 68801 – 68816, for bilateral procedures, use modifier -50)

68801  Dilation of lacrimal punctum, with or without irrigation
68810  Probing of nasolacrimal duct, with or without irrigation;
68811   requiring general anesthesia
68815   with insertion of tube or stent
         See also 92018
68816  Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter
dilation
         (Do not report 68816 in conjunction with 68810, 68811, 68815)
68840  Probing of lacrimal canaliculi, with or without irrigation
68850  Injection of contrast medium for dacryocystography

OTHER PROCEDURES

68899  Unlisted procedure, lacrimal system

AUDITORY SYSTEM

EXTERNAL EAR

INCISION

69000  Drainage external ear, abscess or hematoma; simple
69005   complicated
69020  Drainage external auditory canal, abscess

EXCISION

69100  Biopsy external ear
69105  Biopsy external auditory canal
69110  Excision external ear; partial, simple repair
69120   complete amputation
69140  Excision exostosis(es), external auditory canal
69145  Excision soft tissue lesion, external auditory canal
69150  Radical excision external auditory canal lesion; without neck dissection
69155   with neck dissection

REMOVAL
(For codes 69220, 69222, for bilateral procedures use modifier -50)

69200  Removal foreign body from external auditory canal; without general anesthesia
69205   with general anesthesia
69210  Removal impacted cerumen requiring instrumentation (report one unit for unilateral OR bilateral procedure)

69220  Debridement, mastoidectomy cavity, simple (eg, routine cleaning)

69222  Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)

**REPAIR**

69300  Otoplasty, protruding ear, with or without size reduction
       (For bilateral procedure, report 69300 with modifier 50)

69310  Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection), separate procedure

69320  Reconstruction of external auditory canal for congenital atresia, single stage

**OTHER PROCEDURES**

69399  Unlisted procedure, external ear

**MIDDLE EAR**

**INCISION**

(For codes 69433, 69436, for bilateral procedures use modifier -50)

69420  Myringotomy including aspiration and/or eustachian tube inflation

69421  Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia

69433  Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia

69436  Tympanostomy (requiring insertion of ventilating tube), general anesthesia

69440  Middle ear exploration through postauricular or ear canal incision

69450  Tympanolysis, transcanal

**EXCISION**

69501  Transmastoid antrotomy (simple mastoidectomy)

69502  Mastoidectomy; complete

69505  modified radical

69511  radical

69530  Petrous apicectomy including radical mastoidectomy

69535  Resection temporal bone, external approach

69540  Excision aural polyp

69550  Excision aural glomus tumor; transcanal

69552  transmastoid

69554  extended (extratemporal)

**REPAIR**

69601  Revision mastoidectomy; resulting in complete mastoidectomy
69602  resulting in modified radical mastoidectomy
69603  resulting in radical mastoidectomy
69604  resulting in tympanoplasty
69605  with apicectomy
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  Tymanoplasty 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  Tymanoplasty 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))
69638  with ossicular chain reconstruction
69639  with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, (PORP), total ossicular replacement prosthesis, (TORP))
69641  Tymanoplasty 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)
69675  Tymanic 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
69714  Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715  with mastoidectomy
69717  Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718       with mastoidectomy
69720  Decompression facial nerve, intratemporal; lateral to geniculate ganglion
69725       including medial to geniculate ganglion
69740  Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion
69745       including medial to geniculate ganglion
69799  Unlisted procedure, middle ear

**INNER EAR**

**INCISION AND/OR DESTRUCTION**

69801  Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal
(Do not report 69801 more than once per day)
(Do not report 69801 in conjunction with 69420, 69421, 69433, 69436 when performed on the same ear)
69805  Endolymphatic sac operation; without shunt
69806       with shunt

**EXCISION**

69905  Labyrinthectomy; transcanal
69910       with mastoidectomy
69915  Vestibular nerve section, translabyrinthine approach

**INTRODUCTION**

69930  Cochlear device implantation, with or without mastoidectomy

**OTHER PROCEDURES**

69949  Unlisted procedure, inner ear

**TEMPORAL BONE, MIDDLE FOSSA APPROACH**

69950  Vestibular nerve section, transcranial approach
69955  Total facial nerve decompression and/or repair (may include graft)
69960  Decompression internal auditory canal
69970  Removal of tumor, temporal bone

**OTHER PROCEDURES**

69979  Unlisted procedure, temporal bone, middle fossa approach