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

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

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

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

14. RECEIPT OF HYSTERECTOMY INFORMATION:
Hysterectomies must not be performed for the purpose of sterilization. When hysterectomy
procedures are performed and in all cases when procedures identified by MMIS codes 51925,
58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280,
58285, 58290, 58291, 58292, 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

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

INTERGUMMENTARY SYSTEM

SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES

INCISION AND DRAINAGE

10030  Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous
10035  Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion
10036  each additional lesion (List separately in addition to code for primary procedure)
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 – DEBRIDEEMENT

11000  Debridement of extensive eczematous or infected skin; up to 10% of body surface
11001  each additional 10% of the body surface, or part thereof
11001  (List separately in addition to primary procedure)
11001  (Use 11001 in conjunction with 11000)
11004 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum
   abdominal wall, with or without fascial closure
11006 external genitalia, perineum and abdominal wall, with or without fascial closure
11008 Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection)
   (List separately in addition to primary procedure)
   (Use 11008 in conjunction with 10180, 11004-11006)
   (Do not report 11008 in conjunction with 11000-11001, 11010-11044)
   (Report skin grafts or flaps separately when performed for closure at the same session as 11004-11008)
11010 Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues
11011 skin, subcutaneous tissue, muscle fascia, and muscle
11012 skin, subcutaneous tissue, muscle fascia, muscle, and bone
11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
11043 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle, and/or fascia, if performed); first 20 sq cm or less
11045 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof
   (List separately in addition to primary procedure)
   (Use 11045 in conjunction with 11042)
11046 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof
   (List separately in addition to primary procedure)
   (Use 11046 in conjunction with 11043)
11047 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle, and/or fascia, if performed); each additional 20 sq cm, or part thereof
   (List separately in addition to primary procedure)
   (Use 11047 in conjunction with 11044)

**PARING OR CUTTING**

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

**BIOPSY**
During certain surgical procedures in the integumentary system, such as excision, destruction, or shave removals, the removed tissue is often submitted for pathologic examination. The obtaining of tissue for pathology during the course of these procedures is a routine component of such procedures. This obtaining of tissue is not considered a separate biopsy procedure and is not separately reported. The use of a biopsy procedure code (eg, 11102, 11103, 11104, 11105, 11106, 11107) indicates that the procedure to obtain tissue 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
       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
       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
       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
Excision - Benign Lesions

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

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

The excised diameter is the same whether the surgical defect is repaired in a linear fashion, or reconstructed (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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>11308</td>
<td>lesion diameter over 2.0 cm</td>
</tr>
<tr>
<td>11310</td>
<td>Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less</td>
</tr>
<tr>
<td>11311</td>
<td>lesion diameter 0.6 to 1.0 cm</td>
</tr>
<tr>
<td>11312</td>
<td>lesion diameter 1.1 to 2.0 cm</td>
</tr>
<tr>
<td>11313</td>
<td>lesion diameter over 2.0 cm</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>11400</td>
<td>Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less</td>
</tr>
<tr>
<td>11401</td>
<td>excised diameter 0.6 to 1.0 cm</td>
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<tr>
<td>11402</td>
<td>excised diameter 1.1 to 2.0 cm</td>
</tr>
<tr>
<td>11403</td>
<td>excised diameter 2.1 to 3.0 cm</td>
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<tr>
<td>11404</td>
<td>excised diameter 3.1 to 4.0 cm</td>
</tr>
<tr>
<td>11406</td>
<td>excised diameter over 4.0 cm</td>
</tr>
<tr>
<td>11420</td>
<td>Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less</td>
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<tr>
<td>11421</td>
<td>excised diameter 0.6 to 1.0 cm</td>
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<tr>
<td>11422</td>
<td>excised diameter 1.1 to 2.0 cm</td>
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<tr>
<td>11423</td>
<td>excised diameter 2.1 to 3.0 cm</td>
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<tr>
<td>11424</td>
<td>excised diameter 3.1 to 4.0 cm</td>
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<tr>
<td>11426</td>
<td>excised diameter over 4.0 cm</td>
</tr>
<tr>
<td>11440</td>
<td>Excision, other benign lesion including margins, (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less</td>
</tr>
<tr>
<td>11441</td>
<td>excised diameter 0.6 to 1.0 cm</td>
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<tr>
<td>11442</td>
<td>excised diameter 1.1 to 2.0 cm</td>
</tr>
<tr>
<td>11443</td>
<td>excised diameter 2.1 to 3.0 cm</td>
</tr>
</tbody>
</table>
11444  excised diameter 3.1 to 4.0 cm
11446  excised diameter over 4.0 cm
11450  Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair
        with complex repair
11462  Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair
        with complex repair
11470  Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal or umbilical; with simple or intermediate repair
        with complex repair
        (For bilateral procedure, add modifier 50)

EXCISION - MALIGNANT LESIONS

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

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

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

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

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

11600  Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 0.5 cm or less
        excised diameter 0.6 to 1.0 cm
        excised diameter 1.1 to 2.0 cm
        excised diameter 2.1 to 3.0 cm
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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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</td>
</tr>
<tr>
<td></td>
<td>diameter 0.5 cm or less</td>
</tr>
<tr>
<td>11621</td>
<td>Excision, diameter 0.6 to 1.0 cm</td>
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<tr>
<td>11622</td>
<td>Excision, diameter 1.1 to 2.0 cm</td>
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<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>
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<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</td>
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<td>0.5 cm or less</td>
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<tr>
<td>11641</td>
<td>Excision, diameter 0.6 to 1.0 cm</td>
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<tr>
<td>11642</td>
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<tr>
<td>11643</td>
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</tr>
<tr>
<td>11646</td>
<td>Excision, diameter over 4.0 cm</td>
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**NAILS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<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</td>
</tr>
<tr>
<td></td>
<td>permanent removal;</td>
</tr>
<tr>
<td>11755</td>
<td>Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds)</td>
</tr>
<tr>
<td></td>
<td>(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>
</tbody>
</table>

**PILONIDAL CYST**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

**INTRODUCTION**

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

**REPAIR-COMPLEX**

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

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

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

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

SKIN REPLACEMENT SURGERY

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

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

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

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

**SURGICAL PREPARATION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15002</td>
<td>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</td>
</tr>
<tr>
<td>15003</td>
<td>each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 15003 in conjunction with 15002)</td>
</tr>
<tr>
<td>15004</td>
<td>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</td>
</tr>
<tr>
<td>15005</td>
<td>each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 15005 in conjunction with 15004)</td>
</tr>
<tr>
<td></td>
<td>(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)</td>
</tr>
</tbody>
</table>

**AUTOGRAFT/TISSUE CULTURED AUTOGRAFT**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15040</td>
<td>Harvest of skin for tissue cultured skin autograft, 100 sq cm or less</td>
</tr>
<tr>
<td>15050</td>
<td>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</td>
</tr>
<tr>
<td>15100</td>
<td>Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)</td>
</tr>
<tr>
<td>15101</td>
<td>each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 15101 in conjunction with 15100)</td>
</tr>
<tr>
<td>15110</td>
<td>Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children</td>
</tr>
<tr>
<td>15111</td>
<td>each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 15111 in conjunction with 15110)</td>
</tr>
<tr>
<td>15115</td>
<td>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</td>
</tr>
</tbody>
</table>
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)
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, temporals, masseter, sternocleidomastoid, levator scapulae)
15734 trunk
15736 upper extremity
15738 lower extremity

OTHER FLAPS AND GRAFTS

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

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

OTHER PROCEDURES

15780 Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781 segmental, face
15782 regional, other than face
15783 superficial, any site, (eg, tattoo removal)
15786 Abrasion; single lesion (eg, keratosis, scar)
15787 each additional four lesions or less
(List separately in addition to primary procedure)
(Use 15787 in conjunction with 15786)
15788 Chemical peel, facial; epidermal
15789 dermal
15792 Chemical peel, nonfacial; epidermal
15793 dermal
15819 Cervicoplasty
15820 Blepharoplasty, lower eyelid;
15821 with extensive herniated fat pad
15822 Blepharoplasty, upper eyelid;
15823 with excessive skin weighting down lid
(For bilateral blepharoplasty, add modifier 50)
15824 Rhytidectomy; forehead
(For bilateral rhytidectomy, add modifier 50)
15825 neck with platysmal tightening (platysmal flap, P-flap)
15826 glabellar frown lines
15828 cheek, chin, and neck
15829 superficial musculoaponeurotic system (SMAS) flap
15830 Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
(Do not report 15830 in conjunction with 12031, 12032, 12034, 12035, 12036, 12037, 13100, 13101, 13102, 14000-14001, 14302)
15832 thigh
15833 leg
15834 hip
15835 buttock
15836 arm
15837 forearm or hand
15838 submental fat pad
15839 other area
(For bilateral procedure, add modifier 50)
15840 Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)
(For bilateral procedure, add modifier 50)
15841 free muscle graft (including obtaining graft)
15842 free muscle flap by microsurgical technique
15845 regional muscle transfer
15847 Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
   (List separately in addition to primary procedure)
   (Use 15847 in conjunction with 15830)
15851 Removal of sutures under anesthesia (other than local), other surgeon
15852 Dressing change (for other than burns) under anesthesia (other than local) (See Rule 4)
15860 Intravenous injection of agent (eg, fluorescein) to test vascular flow in flap or graft
15876 Suction assisted lipectomy; head and neck
15877   trunk
15878   upper extremity
15879   lower extremity

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

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

List percentage of body surface involved and depth of burn.

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

DESTRUCTION

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

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

DESTRUCTION, BENIGN OR PREMALIGNANT LESIONS

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

DESTRUCTION, MALIGNANT LESIONS, ANY METHOD

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

**MOHS’ MICROGRAPHIC SURGERY**

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

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

17311  Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks
17312  each additional stage after the first stage, up to 5 tissue blocks
   (List separately in addition to primary procedure)
   (Use 17312 in conjunction with 17311)
17313  Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks
17314  each additional stage after the first stage, up to 5 tissue blocks
Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to primary procedure) (Use 17315 in conjunction with 17314)

OTHER PROCEDURES

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

BREAST

INCISION

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

EXCISION

(To report bilateral procedures, use modifier -50)

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

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

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

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

19081 Biopsy, breast, with placement of breast localization devices(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance
19082 each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)
19083 Biopsy, breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance
19084 each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)
19085 Biopsy, breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance
19086 each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)
19100 Biopsy of breast; percutaneous, needle core, not using needle guidance (separate procedure)
19101 open, incisional
19105 Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma (Do not report 19105 in conjunction with 76940, 76942)
19110 Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct
19112 Excision of lactiferous duct fistula
19120 Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, one or more lesions
19125 Excision of breast lesion identified by pre-operative placement of radiological marker, open; single lesion
19126 each additional lesion separately identified by a preoperative radiological marker (List separately in addition to primary procedure) (Use 19126 in conjunction with code 19125) (Do not report in conjunction with 32100, 32503, 32504, 32551, 32554, 32555)

INTRODUCTION

19281 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including mammographic guidance
19282 each additional lesion, including mammographic guidance
(List separately in addition to primary procedure)

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

19284 each additional lesion, including stereotactic guidance

(Use 19283 in conjunction with code 19284)

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

(Use 19285 in conjunction with code 19286)

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

(Use 19287 in conjunction with code 19288)

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

(List separately in addition to primary procedure)

19297 concurrent with partial mastectomy

(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 with axillary lymphadenectomy

19303 Mastectomy, simple, complete

19305 Mastectomy, radical, including pectoral muscles, axillary lymph nodes

19306 Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)

19307 Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

REPAIR AND/OR RECONSTRUCTION

(To report bilateral procedures, use modifier -50)

19316 Mastopexy (unilateral)

19318 Reduction mammoplasty (unilateral)

19324 Mammaplasty, augmentation; without prosthetic implant

19325 with prosthetic implant
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19328</td>
<td>Removal of intact mammary implant</td>
</tr>
<tr>
<td>19330</td>
<td>Removal of implant material</td>
</tr>
<tr>
<td>19340</td>
<td>Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction</td>
</tr>
<tr>
<td>19342</td>
<td>Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction</td>
</tr>
<tr>
<td>19350</td>
<td>Nipple/areola reconstruction</td>
</tr>
<tr>
<td>19355</td>
<td>Correction of inverted nipples</td>
</tr>
<tr>
<td>19357</td>
<td>Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion</td>
</tr>
<tr>
<td>19361</td>
<td>Breast reconstruction with latissimus dorsi flap, without prosthetic implant</td>
</tr>
<tr>
<td>19362</td>
<td>Breast reconstruction with free flap</td>
</tr>
<tr>
<td></td>
<td>(19364 includes harvesting of the flap, microvascular transfer, closure of the donor site, and inset shaping the flap into a breast)</td>
</tr>
<tr>
<td>19366</td>
<td>Breast reconstruction with other technique</td>
</tr>
<tr>
<td>19367</td>
<td>Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;</td>
</tr>
<tr>
<td></td>
<td>with microvascular anastomosis (supercharging)</td>
</tr>
<tr>
<td>19368</td>
<td>Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site</td>
</tr>
<tr>
<td>19369</td>
<td>Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site</td>
</tr>
<tr>
<td></td>
<td>with microvascular anastomosis (supercharging)</td>
</tr>
<tr>
<td>19370</td>
<td>Open periprosthetic capsulotomy, breast</td>
</tr>
<tr>
<td>19371</td>
<td>Periprosthetic capsulectomy, breast</td>
</tr>
<tr>
<td>19380</td>
<td>Revision of reconstructed breast</td>
</tr>
<tr>
<td>19396</td>
<td>Preparation of moulage for custom breast implant</td>
</tr>
</tbody>
</table>

**OTHER PROCEDURES**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19499</td>
<td>Unlisted procedure, breast</td>
</tr>
</tbody>
</table>

**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

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
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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20100</td>
<td>Exploration of penetrating wound (separate procedure); neck</td>
</tr>
<tr>
<td>20101</td>
<td>chest</td>
</tr>
<tr>
<td>20102</td>
<td>abdomen/flank/back</td>
</tr>
<tr>
<td>20103</td>
<td>extremity</td>
</tr>
</tbody>
</table>

**EXCISION**

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

**INTRODUCTION OR REMOVAL**

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

**REPLANTATION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20802</td>
<td>Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation</td>
</tr>
<tr>
<td>20805</td>
<td>Replantation, forearm, (includes radius and ulna to radial carpal joint), complete amputation</td>
</tr>
<tr>
<td>20808</td>
<td>Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation</td>
</tr>
<tr>
<td>20816</td>
<td>Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation</td>
</tr>
<tr>
<td>20822</td>
<td>Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation</td>
</tr>
<tr>
<td>20824</td>
<td>Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputation</td>
</tr>
<tr>
<td>20827</td>
<td>Replantation, thumb (includes distal tip to MP joint), complete amputation</td>
</tr>
<tr>
<td>20838</td>
<td>Replantation, foot, complete amputation</td>
</tr>
</tbody>
</table>

**GRAFTS (OR IMPLANTS)**

Codes for obtaining autogenous bone, cartilage, tendon, fascia lata grafts, or other tissues through separate skin/fascial incisions should be reported separately unless the code descriptor references the harvesting of the graft or implant (eg, includes obtaining graft).
Do not append modifier –62 to bone graft codes 20900-20938.

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

**OTHER PROCEDURES**

- **20950** Monitoring of interstitial fluid pressure (includes insertion of device eg, wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome
- **20955** Bone graft with microvascular anastomosis; fibula
- **20956** iliac crest
- **20957** metatarsal
- **20962** other than fibula, iliac crest, or metatarsal
- **20969** Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe
- **20970** iliac crest
- **20972** metatarsal
- **20973** great toe with web space
- **20974** Electrical stimulation to aid bone healing; noninvasive (nonoperative)
- **20975** invasive (operative)
- **20979** Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)
- **20982** Ablation therapy for reduction or eradication of 1 or more bone tumors
  (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency
- **20999** Unlisted procedure, musculoskeletal system, general

**HEAD**
Skull, facial bones and temporomandibular joint.

**INCISION**

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

**EXCISION**

21011 Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm
21012 2 cm or greater
21013 Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm
21014 2 cm or greater
21015 Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm
21016 2 cm or greater
21025 Excision of bone (eg, for osteomyelitis or bone abscess); mandible
21026  facial bone(s)
21029 Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)
21030 Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage
21031 Excision of torus mandibularis
21032 Excision of maxillary torus palatinus
21034 Excision of malignant tumor of maxilla or zygoma
21040 Excision of benign tumor or cyst of mandible, by enucleation and/or curettage
21044 Excision of malignant tumor of mandible;
21045  radical resection
21046 Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))
21047  requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))
21048 Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))
21049  requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))
21050 Condylectomy, temporomandibular joint; (separate procedure)
   (For bilateral procedures use modifier -50)
21060 Meniscectomy, partial or complete, temporomandibular joint (separate procedure)
   (For bilateral procedures use modifier -50)
21070 Coronoidectomy (separate procedure)
   (For bilateral procedures use modifier -50)

**MANIPULATION**

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

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

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

INTRODUCTION OR REMOVAL

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

REPAIR, REVISION, AND/OR RECONSTRUCTION

21120 Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121 sliding osteotomy, single piece
21122 sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123 sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125 Augmentation, mandibular body or angle; prosthetic material
21127 with bone graft, onlay or interpositional (includes obtaining autograft)
21137 Reduction forehead; contouring only
21138 contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139 contouring and setback of anterior frontal sinus wall
21141 Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
21142 two pieces, segment movement in any direction, without bone graft
21143 three or more pieces, segment movement in any direction, without bone graft
21145 single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21146</td>
<td>two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)</td>
</tr>
<tr>
<td>21147</td>
<td>three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)</td>
</tr>
<tr>
<td>21150</td>
<td>Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)</td>
</tr>
<tr>
<td>21151</td>
<td>any direction, requiring bone grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21154</td>
<td>Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I</td>
</tr>
<tr>
<td>21155</td>
<td>with LeFort I</td>
</tr>
<tr>
<td>21159</td>
<td>Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I</td>
</tr>
<tr>
<td>21160</td>
<td>with LeFort I</td>
</tr>
<tr>
<td>21172</td>
<td>Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21175</td>
<td>Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21179</td>
<td>Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)</td>
</tr>
<tr>
<td>21180</td>
<td>with autograft (includes obtaining grafts)</td>
</tr>
<tr>
<td>21181</td>
<td>Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial</td>
</tr>
<tr>
<td>21182</td>
<td>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</td>
</tr>
<tr>
<td>21183</td>
<td>total area of bone grafting greater than 40 sq cm but less than 80 sq cm</td>
</tr>
<tr>
<td>21184</td>
<td>total area of bone grafting greater than 80 sq cm</td>
</tr>
<tr>
<td>21188</td>
<td>Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21193</td>
<td>Reconstruction of mandibular rami, horizontal, vertical, &quot;C&quot;, or &quot;L&quot; osteotomy; without bone graft</td>
</tr>
<tr>
<td>21194</td>
<td>with bone graft (includes obtaining graft)</td>
</tr>
<tr>
<td>21195</td>
<td>Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation</td>
</tr>
<tr>
<td>21196</td>
<td>with internal rigid fixation</td>
</tr>
<tr>
<td>21198</td>
<td>Osteotomy, mandible, segmental;</td>
</tr>
<tr>
<td>21199</td>
<td>with genioglossus advancement</td>
</tr>
<tr>
<td>21206</td>
<td>Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)</td>
</tr>
<tr>
<td>21208</td>
<td>Osteoplasty, facial bones; augmentation (autograft, allograft or prosthetic implant)</td>
</tr>
<tr>
<td>21209</td>
<td>reduction</td>
</tr>
<tr>
<td>21210</td>
<td>Graft, bone; nasal, maxillary and malar areas (includes obtaining graft)</td>
</tr>
<tr>
<td>21215</td>
<td>mandible (includes obtaining graft)</td>
</tr>
<tr>
<td>21230</td>
<td>Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)</td>
</tr>
<tr>
<td>21235</td>
<td>ear cartilage, autograft, to nose or ear (includes obtaining graft)</td>
</tr>
<tr>
<td>21240</td>
<td>Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)</td>
</tr>
</tbody>
</table>
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)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21450</td>
<td>Closed treatment of mandibular fracture; without manipulation</td>
</tr>
<tr>
<td>21451</td>
<td>with manipulation</td>
</tr>
<tr>
<td>21452</td>
<td>Percutaneous treatment of mandibular fracture, with external fixation</td>
</tr>
<tr>
<td>21453</td>
<td>Closed treatment of mandibular fracture with interdental fixation</td>
</tr>
<tr>
<td>21454</td>
<td>Open treatment of mandibular fracture with external fixation</td>
</tr>
<tr>
<td>21456</td>
<td>Closed treatment of mandibular condylar fracture</td>
</tr>
<tr>
<td>21457</td>
<td>Open treatment of complicated mandibular fracture by multiple surgical</td>
</tr>
<tr>
<td></td>
<td>approaches including internal fixation, interdental fixation, and/or wiring</td>
</tr>
<tr>
<td></td>
<td>of dentures or splints</td>
</tr>
<tr>
<td>21480</td>
<td>Closed treatment of temporomandibular dislocation, initial or subsequent</td>
</tr>
<tr>
<td>21485</td>
<td>complicated (eg, recurrent requiring intermaxillary fixation or splinting),</td>
</tr>
<tr>
<td></td>
<td>initial or subsequent</td>
</tr>
<tr>
<td>21490</td>
<td>Open treatment of temporomandibular dislocation</td>
</tr>
</tbody>
</table>

**OTHER PROCEDURES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21497</td>
<td>Interdental wiring, for condition other than fracture</td>
</tr>
<tr>
<td>21499</td>
<td>Unlisted musculoskeletal procedure, head</td>
</tr>
</tbody>
</table>

**NECK (SOFT TISSUES) AND THORAX**

**INCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21501</td>
<td>Incision and drainage, deep abscess or hematoma, soft tissues of neck of</td>
</tr>
<tr>
<td></td>
<td>thorax;</td>
</tr>
<tr>
<td>21502</td>
<td>with partial rib ostectomy</td>
</tr>
<tr>
<td>21510</td>
<td>Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone</td>
</tr>
<tr>
<td></td>
<td>abscess), thorax</td>
</tr>
</tbody>
</table>

**EXCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21550</td>
<td>Biopsy, soft tissue of neck or thorax</td>
</tr>
<tr>
<td>21552</td>
<td>Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm</td>
</tr>
<tr>
<td></td>
<td>or greater</td>
</tr>
<tr>
<td>21554</td>
<td>Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg,</td>
</tr>
<tr>
<td></td>
<td>intramuscular); 5 cm or greater</td>
</tr>
<tr>
<td>21555</td>
<td>Excision tumor, soft tissue of neck or anterior thorax, subcutaneous; less</td>
</tr>
<tr>
<td></td>
<td>than 3 cm</td>
</tr>
<tr>
<td>21556</td>
<td>subfascial (eg, intramuscular); less than 5 cm</td>
</tr>
<tr>
<td>21557</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior</td>
</tr>
<tr>
<td></td>
<td>thorax; less than 5 cm</td>
</tr>
<tr>
<td>21558</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>21600</td>
<td>Excision of rib, partial</td>
</tr>
<tr>
<td>21601</td>
<td>Excision of chest wall tumor including rib(s)</td>
</tr>
<tr>
<td>21602</td>
<td>Excision of chest wall tumor involving rib(s), with plastic reconstruction;</td>
</tr>
<tr>
<td></td>
<td>without mediastinal lymphadenectomy</td>
</tr>
<tr>
<td>21603</td>
<td>with mediastinal lymphadenectomy</td>
</tr>
<tr>
<td>21610</td>
<td>Costotransversectomy (separate procedure)</td>
</tr>
<tr>
<td>21615</td>
<td>Excision first and/or cervical rib;</td>
</tr>
<tr>
<td>21616</td>
<td>with sympathectomy</td>
</tr>
</tbody>
</table>
21620  Ostectomy of sternum, partial
21627  Sternal debridement
21630  Radical resection of sternum;
21632   with mediastinal lymphadenectomy

REPAIR, REVISION AND/OR RECONSTRUCTION

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

FRACTURE AND/OR DISLOCATION

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

OTHER PROCEDURES

21899  Unlisted procedure, neck or thorax

BACK AND FLANK

EXCISION

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

SPINE (VERTEBRAL COLUMN)

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

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

Within the SPINE section, instrumentation is reported separately and in addition to arthrodesis. To report instrumentation procedures performed with definitive vertebral procedure(s), see codes 22840-22848,22853,22854,22859. 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 (e.g., 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)

ANTEROIOR 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-CI-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)
Physician - Procedure Codes, Section 5 - Surgery

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

OTHER PROCEDURES

22899  Unlisted procedure, spine
ABDOMEN

EXCISION

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

OTHER PROCEDURES

22999 Unlisted procedure, abdomen, musculoskeletal system

SHOULDER

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

INCISION

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

EXCISION

23065 Biopsy, soft tissues; superficial
23066 deep
23071 Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater
23073 Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greater
23075 Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm
23076 Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm
23077 Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; less than 5 cm
23078 5 cm or greater
23100 Arthrotomy, glenohumeral joint, including biopsy
23101 Arthrotomy, acromioclavicular joint or sternoclavicular joint, including biopsy and/or excision of torn cartilage
23105 Arthrotomy, glenohumeral joint with synovectomy, with or without biopsy
23106 sternoclavicular joint, with synovectomy, with or without biopsy
23107 Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body
<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<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; 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; 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>Procedure 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>Procedure 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>
<tr>
<td>23440</td>
<td>Resection or transplantation of long tendon of biceps</td>
</tr>
<tr>
<td>23450</td>
<td>Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>23455</td>
<td>with labral repair (e.g., Bankart procedure)</td>
</tr>
<tr>
<td>23460</td>
<td>Capsulorrhaphy, anterior, any type; with bone block</td>
</tr>
<tr>
<td>23462</td>
<td>with coracoid process transfer</td>
</tr>
<tr>
<td>23465</td>
<td>Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block</td>
</tr>
<tr>
<td>23466</td>
<td>Capsulorrhaphy, glenohumeral joint, any type multi-directional instability</td>
</tr>
<tr>
<td>23470</td>
<td>Arthroplasty, glenohumeral joint; hemiarthroplasty</td>
</tr>
<tr>
<td>23472</td>
<td>total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)</td>
</tr>
<tr>
<td>23473</td>
<td>Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component</td>
</tr>
<tr>
<td>23474</td>
<td>humeral and glenoid component</td>
</tr>
<tr>
<td>23480</td>
<td>Osteotomy, clavicle, with or without internal fixation;</td>
</tr>
<tr>
<td>23485</td>
<td>with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)</td>
</tr>
<tr>
<td>23490</td>
<td>Prophylactic treatment (nailing, pinning, plating, or wiring) with or without methylmethacrylate; clavicle</td>
</tr>
<tr>
<td>23491</td>
<td>proximal humerus</td>
</tr>
</tbody>
</table>

**FRACTURE AND/OR DISLOCATION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>23500</td>
<td>Closed treatment of clavicular fracture; without manipulation</td>
</tr>
<tr>
<td>23505</td>
<td>with manipulation</td>
</tr>
<tr>
<td>23515</td>
<td>Open treatment of clavicular fracture, includes internal fixation, when performed</td>
</tr>
<tr>
<td>23520</td>
<td>Closed treatment of sternoclavicular dislocation; without manipulation</td>
</tr>
<tr>
<td>23525</td>
<td>with manipulation</td>
</tr>
<tr>
<td>23530</td>
<td>Open treatment of sternoclavicular dislocation, acute or chronic;</td>
</tr>
<tr>
<td>23532</td>
<td>with fascial graft (includes obtaining graft)</td>
</tr>
<tr>
<td>23540</td>
<td>Closed treatment of acromioclavicular dislocation; without manipulation</td>
</tr>
<tr>
<td>23545</td>
<td>with manipulation</td>
</tr>
<tr>
<td>23550</td>
<td>Open treatment of acromioclavicular dislocation, acute or chronic;</td>
</tr>
<tr>
<td>23552</td>
<td>with fascial graft (includes obtaining graft)</td>
</tr>
<tr>
<td>23570</td>
<td>Closed treatment of scapular fracture; without manipulation</td>
</tr>
<tr>
<td>23575</td>
<td>with manipulation, with or without skeletal traction (with or without shoulder joint involvement)</td>
</tr>
<tr>
<td>23585</td>
<td>Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation, when performed</td>
</tr>
<tr>
<td>23600</td>
<td>Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation</td>
</tr>
<tr>
<td>23605</td>
<td>with manipulation, with or without skeletal traction</td>
</tr>
<tr>
<td>23615</td>
<td>Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed;</td>
</tr>
<tr>
<td>23616</td>
<td>with proximal humeral prosthetic replacement</td>
</tr>
<tr>
<td>23620</td>
<td>Closed treatment of greater humeral tuberosity fracture; without manipulation</td>
</tr>
<tr>
<td>23625</td>
<td>with manipulation</td>
</tr>
<tr>
<td>23630</td>
<td>Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed</td>
</tr>
</tbody>
</table>
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  Interthoracoscopicar 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>
<tr>
<td>24220</td>
<td>Injection procedure for elbow arthrography</td>
</tr>
</tbody>
</table>
**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
24332  Tenolysis, triceps
24340  Tenodesis of biceps tendon at elbow (separate procedure)
24341  Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)
24342  Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
24343  Repair lateral collateral ligament, elbow, with local tissue
24344  Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24345  Repair medial collateral ligament, elbow, with local tissue
24346  Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24357  Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer’s elbow); percutaneous
24358  Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer’s elbow); debridement, soft tissue and/or bone, open
24359  Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer’s elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment
24360  Arthroplasty, elbow; with membrane (eg, fascial)
24361   with distal humeral prosthetic replacement
24362   with implant and fascia lata ligament reconstruction
24363   with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)
24365  Arthroplasty, radial head;
24366   with implant
24370  Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component
24371   humeral and ulnar component
24400  Osteotomy, humerus, with or without internal fixation
24410  Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)
24420  Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876)
24430  Repair of nonunion or malunion, humerus; without graft (eg, compression technique, etc)
24435   with iliac or other autograft (includes obtaining graft)
24470  Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus)
24495  Decompression fasciotomy, forearm, with brachial artery exploration
24498  Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, humeral shaft

**FRACTURE AND/OR DISLOCATION**

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

ARTHRODESIS

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

AMPUTATION

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

OTHER PROCEDURES

24999  Unlisted procedure, humerus or elbow

FOREARM AND WRIST

Radius, ulna, carpal bones and joints.

INCISION

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

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

INTRODUCTION OR REMOVAL
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25246</td>
<td>Injection procedure for wrist arthrography</td>
</tr>
<tr>
<td>25248</td>
<td>Exploration with removal of deep foreign body, forearm or wrist</td>
</tr>
<tr>
<td>25250</td>
<td>Removal of wrist prosthesis; (separate procedure)</td>
</tr>
<tr>
<td>25251</td>
<td>complicated, including total wrist</td>
</tr>
<tr>
<td>25259</td>
<td>Manipulation, wrist, under an anesthesia</td>
</tr>
</tbody>
</table>

**REPAIR, REVISION AND/OR RECONSTRUCTION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25260</td>
<td>Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle</td>
</tr>
<tr>
<td>25263</td>
<td>secondary, single, each tendon or muscle</td>
</tr>
<tr>
<td>25265</td>
<td>secondary, with free graft (includes obtaining graft) each tendon or muscle</td>
</tr>
<tr>
<td>25270</td>
<td>Repair, tendon or muscle, extensor; forearm and/or wrist; primary, single, each tendon or muscle</td>
</tr>
<tr>
<td>25272</td>
<td>secondary, single, each tendon or muscle</td>
</tr>
<tr>
<td>25274</td>
<td>secondary, with free graft (includes obtaining graft), each tendon or muscle</td>
</tr>
<tr>
<td>25275</td>
<td>Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft)</td>
</tr>
<tr>
<td>25280</td>
<td>Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist; single, each tendon</td>
</tr>
<tr>
<td>25290</td>
<td>Tenotomy, open, flexor or extensor tendon, forearm and/or wrist single, each tendon</td>
</tr>
<tr>
<td>25295</td>
<td>Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon</td>
</tr>
<tr>
<td>25300</td>
<td>Tenodesis at wrist; flexors of fingers</td>
</tr>
<tr>
<td>25301</td>
<td>extensors of fingers</td>
</tr>
<tr>
<td>25310</td>
<td>Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon</td>
</tr>
<tr>
<td>25312</td>
<td>with tendon graft(s) (includes obtaining graft), each tendon</td>
</tr>
<tr>
<td>25315</td>
<td>Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist;</td>
</tr>
<tr>
<td>25316</td>
<td>with tendon(s) transfer</td>
</tr>
<tr>
<td>25320</td>
<td>Capsulorrhaphy or reconstruction, wrist, open, (eg, capsulodesis, ligament repair, tendon transfer or</td>
</tr>
<tr>
<td></td>
<td>graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability</td>
</tr>
<tr>
<td>25332</td>
<td>Arthroplasty, wrist, with or without interposition, with or without external or internal fixation</td>
</tr>
<tr>
<td>25335</td>
<td>Centralization of wrist on ulna (eg, radial club hand)</td>
</tr>
<tr>
<td>25337</td>
<td>Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by</td>
</tr>
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<td></td>
<td>soft tissue stabilization (eg, tendon transfer, tendon graft or weave, or tenodesis) with or</td>
</tr>
<tr>
<td></td>
<td>without open reduction of distal radioulnar joint</td>
</tr>
<tr>
<td>25350</td>
<td>Osteotomy, radius; distal third</td>
</tr>
<tr>
<td>25355</td>
<td>middle or proximal third</td>
</tr>
<tr>
<td>25360</td>
<td>Osteotomy; ulna</td>
</tr>
<tr>
<td>25365</td>
<td>radius AND ulna</td>
</tr>
<tr>
<td>25370</td>
<td>Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR</td>
</tr>
<tr>
<td></td>
<td>ulna</td>
</tr>
<tr>
<td>25375</td>
<td>radius AND ulna</td>
</tr>
<tr>
<td>25390</td>
<td>Osteoplasty, radius OR ulna; shortening</td>
</tr>
</tbody>
</table>
25391  lengthening with autograft
25392 Osteoplasty, radius AND ulna; shortening (excluding 64876)
25393  lengthening with autograft
25394 Osteoplasty, carpal bone, shortening
25400 Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)
25405  with autograft (includes obtaining graft)
25415 Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)
25420  with autograft (includes obtaining graft)
25425 Repair of defect with autograft; radius OR ulna
25426  radius AND ulna
25430 Insertion of vascular pedicle into carpal bone (eg, Hori procedure)
25431 Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone
25440 Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)
25441 Arthroplasty with prosthetic replacement; distal radius
25442  distal ulna
25443  scaphoid carpal (navicular)
25444  lunate
25445  trapezium
25446  distal radius and partial or entire carpus ("total wrist")
25447 Arthroplasty interposition, intercarpal or carpometacarpal joints
25449 Revision of arthroplasty, including removal of implant, wrist joint
25450 Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna
25455  distal radius AND ulna
25490 Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius
25491  ulna
25492  radius AND ulna

**FRACTURE AND/OR DISLOCATION**

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

ARTHRODESIS

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

**AMPUTATION**

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

**OTHER PROCEDURES**

25999  Unlisted procedure, forearm or wrist

**HAND AND FINGERS**

**INCISION**

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

**EXCISION**

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

INTRODUCTION OR REMOVAL

26320  Removal of implant from finger or hand
REPAIR, REVISION AND/OR RECONSTRUCTION

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

**FRACTURE AND/OR DISLOCATION**
26600 Closed treatment of metacarpal fracture, single; without manipulation, each bone
26605 with manipulation, each bone
26607 Closed treatment of metacarpal fracture, with manipulation, with external fixation, each bone
26608 Percutaneous skeletal fixation of metacarpal fracture, each bone
26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone
26641 Closed treatment of carpometacarpal dislocation, thumb, with manipulation
26645 Closed treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation
26650 Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation
26665 Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed
26670 Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; without anesthesia
26674 requiring anesthesia
26676 Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb, with manipulation, each joint
26685 Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint
26686 complex, multiple or delayed reduction
26700 Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia
26704 requiring anesthesia
26706 Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation
26715 Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed
26720 Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each
26724 with manipulation, with or without skin or skeletal traction, each
26727 Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each
26735 Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each
26740 Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; without manipulation, each
26742 with manipulation, each
26746 Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each
26750 Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each
26755 with manipulation, each
26756 Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each
26765 Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each
26770 Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia
26775 requiring anesthesia
26776 Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation
26785 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single

**ARTHRODESIS**

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

**AMPUTATION**

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

**OTHER PROCEDURES**
26989  Unlisted procedure, hands or fingers

**PELVIS AND HIP JOINT**

Including head and neck of femur.

**INCISION**

26990  Incision and drainage; pelvis or hip joint area; deep abscess or hematoma
26991   infected bursa
26992  Incision, bone cortex, pelvis and/or hip joint (eg, for osteomyelitis or bone abscess)
27000  Tenotomy, adductor of hip, percutaneous, (separate procedure)
27001  Tenotomy, adductor of hip, open
27003  Tenotomy, adductor, subcutaneous, open, with obturator neurectomy
27005  Tenotomy, hip flexor(s), open (separate procedure)
27006  Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)
27025  Fasciotomy, hip or thigh, any type
   (For 27001, 27003, 27025, to report bilateral procedures, use modifier -50)
27027  Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-
   minimus, gluteus maximus, iliopsoas, and/ or tensor fascia lata muscle), unilateral
   (To report bilateral procedure, use modifier -50)
27030  Arthrotomy, hip, with drainage (eg, infection)
27033  Arthrotomy, hip, including exploration or removal of loose or foreign body
27035  Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral or
   obturator nerves
27036  Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release
   of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus
   femoris, sartorius, iliopsoas)

**EXCISION**

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

**INTRODUCTION OR REMOVAL**

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27097</td>
<td>Release or recession, hamstring, proximal</td>
</tr>
<tr>
<td>27098</td>
<td>Transfer, adductor to ischium</td>
</tr>
<tr>
<td>27100</td>
<td>Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft)</td>
</tr>
<tr>
<td>27105</td>
<td>Transfer paraspinal muscle to hip (includes fascial or tendon extension graft)</td>
</tr>
<tr>
<td>27110</td>
<td>Transfer iliopsoas; to greater trochanter of femur</td>
</tr>
<tr>
<td>27111</td>
<td>to femoral neck</td>
</tr>
<tr>
<td>27120</td>
<td>Acetabuloplasty; (eg, Whitman, Colonna Haygroves, or cup type)</td>
</tr>
<tr>
<td>27122</td>
<td>resection, femoral head (Girdlestone procedure)</td>
</tr>
<tr>
<td>27125</td>
<td>Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)</td>
</tr>
</tbody>
</table>
27130  Arthroplasty, acetabular and proximal femoral prosthetic replacement, (total hip arthroplasty), with or without autograft or allograft
27132  Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
27134  Revision of total hip arthroplasty; both components, with or without autograft or allograft
27137  acetabular component only, with or without autograft or allograft
27138  femoral component only, with or without allograft
27140  Osteotomy and transfer of greater trochanter of femur (separate procedure)
27146  Osteotomy, iliac, acetabular or innominate bone;
27147  with open reduction of hip
27151  with femoral osteotomy
27156  with femoral osteotomy and with open reduction of hip
27158  Osteotomy, pelvis, bilateral (eg, congenital malformation)
27161  Osteotomy, femoral neck (separate procedure)
27165  Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast
27170  Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)
27175  Treatment of slipped femoral epiphysis; by traction, without reduction
27176  by single or multiple pinning, in situ
27177  Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)
27178  closed manipulation with single or multiple pinning
27179  osteoplasty of femoral neck (Heyman type procedure)
27181  osteotomy and internal fixation
27185  Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur
27187  Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur

FRACTURE AND/OR DISLOCATION

27197  Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) or the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation
27198  with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)
27200  Closed treatment of coccygeal fracture
27202  Open treatment of coccygeal fracture
27215  Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, (eg, pelvic fracture(s) which do not disrupt the pelvic ring), with internal fixation
27216  Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)
Physician - Procedure Codes, Section 5 - Surgery

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); with femoral shaft shortening

27259  Closed treatment of post hip arthroplasty dislocation; without anesthesia

27266  requiring regional or general anesthesia

27267  Closed treatment of femoral fracture, proximal end, head; without manipulation

27268  Closed treatment of femoral fracture, proximal end, head; with manipulation
27269  Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed

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

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

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

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

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

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

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

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

REPAIR, REVISION, AND/OR RECONSTRUCTION
27380  Suture of infrapatellar tendon; primary
27381   secondary reconstruction, including fascial or tendon graft
27385  Suture of quadriceps or hamstring muscle rupture; primary
27386   secondary reconstruction, including fascial or tendon graft
27390  Tenotomy, open, hamstring, knee to hip; single tendon
27391   multiple tendons, one leg
27392   multiple tendons, bilateral
27393  Lengthening of hamstring tendon; single tendon
27394  multiple tendons, one leg
27395  multiple tendons, bilateral
27396  Transplant or transfer (with muscle redirection or rerouting), thigh (eg, extensor to flexor); single tendon
27397  multiple tendons
27400  Transfer tendon or muscle, hamstrings to femur (eg, Eggers type procedure)
27403  Arthrotomy with open meniscus repair, knee
27405  Repair, primary, torn ligament and/or capsule, knee; collateral
cruciate
27409  collateral and cruciate ligaments
27415  Osteochondral allograft, knee, open
27416  Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])
(Do not report 27416 in conjunction with 27415, 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)
27418  Anterior tibial tubercleplasty (eg, Maquet type procedure)
27420  Reconstruction of dislocating patella; (eg, Hauser type procedure)
27422  with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)
27424  with patellectomy
27425  Lateral retinacular release open
27427  Ligamentous reconstruction (augmentation), knee; extra-articular
27428  intra-articular (open)
27429  intra-articular (open) and extra-articular
27430  Quadricepsplasty (eg, Bennett or Thompson type)
27435  Capsulotomy, posterior release, knee
27437  Arthroplasty, patella; without prosthesis
27438  with prosthesis
27440  Arthroplasty, knee, tibial plateau;
27441  with debridement and partial synovectomy
27442  Arthroplasty, femoral condyles or tibial plateau(s), knee;
27443  with debridement and partial synovectomy
27445  Arthroplasty, knee, hinge prosthesis (eg, Walldius type)
27446  Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
27447  medial AND lateral compartments with or without patella resurfacing (total knee replacement)
27448  Osteotomy, femur, shaft or supracondylar; without fixation
27450  with fixation
27454  Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft, (eg, Sofield type procedure)
27455  Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)); before epiphyseal closure
27457  after epiphyseal closure
(To report 27448-27450, 27455-27457 as bilateral procedures, use modifier -50)
27465 Osteoplasty, femur; shortening (excluding 64876)
27466 lengthening
27468 combined, lengthening and shortening with femoral segment transfer
27470 Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)
27472 with iliac or other autogenous bone graft (includes obtaining graft)
27475 Arrest, epiphyseal, any method (eg, epiphysiodesis); distal femur
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
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);
with debridement of nonviable muscle and/or nerve
27498 Decompression fasciotomy, thigh and/or knee, multiple compartments;
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); unicodylar, includes internal fixation, when performed
27536 bicondylar, with or without internal fixation
27538 Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation
27540 Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed
27550 Closed treatment of knee dislocation; without anesthesia
27552 requiring anesthesia
27556 Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction
27557 with primary ligamentous repair
27558 with primary ligamentous repair, with augmentation/reconstruction
27560 Closed treatment of patellar dislocation; without anesthesia
27562 requiring anesthesia
27566 Open treatment of patellar dislocation, with or without partial or total patellectomy

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

ARTHRODESIS
27580 Arthrodesis, knee, any technique

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

OTHER PROCEDURES
27599 Unlisted procedure, femur or knee
LEG (TIBIA AND FIBULA) AND ANKLE JOINT

INCISION

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

EXCISION

27613  Biopsy, soft tissues; superficial
27614  deep (subfascial or intramuscular)
27615  Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm
27616  5 cm or greater
27618  Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm
27619  Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm
27620  Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body
27625  Arthrotomy, with synovectomy, ankle;
27626  including tenosynovectomy
27630  Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion), leg and/or ankle
27632  Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater
27634  Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater
27635  Excision or curettage of bone cyst or benign tumor, tibia or fibula;
27637  with autograft (includes obtaining graft)
27638  with allograft
27640  Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis);
27641  tibia
27642  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  
(Use 27692 in conjunction with 27690, 27691)  
27695 Repair, primary, disrupted ligament, ankle; collateral  
27696 both collateral ligaments  
27698 Repair, secondary disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)  
27700 Arthroplasty, ankle;  
27702 with implant (total ankle)  
27703 revision, total ankle  
27704 Removal of ankle implant  
27705 Osteotomy; tibia  
27707 fibula  
27709 tibia and fibula  
27712 multiple, with realignment on intramedullary rod (eg, Sofield type procedure)  
27715 Osteoplasty, tibia and fibula, lengthening or shortening  
27720 Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)  
27722 with sliding graft  
27724 with iliac or other autograft (includes obtaining graft)  
27725 by synostosis, with fibula, any method  
27726 repair of fibula nonunion and/or malunion with internal fixation  
(Do not report 27726 in conjunction with 27707)
27727  Repair of congenital pseudarthrosis, tibia
27730  Arrest, epiphyseal (epiphysiodesis), open; distal tibia
        distal fibula
27734  distal tibia and fibula
27740  Arrest epiphyseal, (epiphysiodesis), any method; combined, proximal and distal tibia and
        fibula;
        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 tibiobifibular joint (syndesmosis) disruption, includes internal fixation, when performed
27830  Closed treatment of proximal tibiobifibular joint dislocation; without anesthesia
27831  requiring anesthesia
27832  Open treatment of proximal tibiobifibular 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, tibiobifibular 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 (Syne, Pirogoff type procedures), with plastic closure and resection of nerves
27889  Ankle disarticulation

OTHER PROCEDURES

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

**FOOT AND TOES**

**INCISION**

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

**EXCISION**

28039  Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater
28041  Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater
28043  Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm
28045  Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm
28046  Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm
28047   3 cm or greater
28050  Arthrotomy with biopsy; intertarsal or tarsometatarsal joint
28052   metatarsophalangeal joint
28054   interphalangeal joint
28055  Neurectomy, intrinsic musculature of foot
28060  Fasciectomy, plantar fascia; partial (separate procedure)
28062   radical (separate procedure)
28070  Synovectomy; intertarsal or tarsometatarsal joint, each
28072   metatarsophalangeal joint, each
28080  Excision of interdigital (Morton) neuroma, single, each
28086  Synovectomy, tendon sheath, foot; flexor
28088   extensor
28090  Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (cyst or
        ganglion); foot
28092   toe(s), each
28100  Excision or curettage of bone cyst or benign tumor, talus or calcaneus;
28102   with iliac or other autograft (includes obtaining graft)
28103   with allograft
28104  Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus;
28106  with iliac or other autograft (includes obtaining graft)
28107  with allograft
28108  Excision or curettage of bone cyst or benign tumor, phalanges of foot
28110  Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
28111  Ostectomy, complete excision; first metatarsal head
28112  other metatarsal head (second, third or fourth)
28113  fifth metatarsal head
28114  all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (Clayton type procedure)
28116  Ostectomy, excision of tarsal coalition
28118  Ostectomy, calcaneus;
28119  for spur, with or without plantar fascial release
28120  Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus
28122  tarsal or metatarsal bone except talus or calcaneus
28124  phalanx of toe
28126  Resection, partial or complete, phalangeal base, each toe
28130  Talectomy (astragalectomy)
28140  Metatarsectomy
28150  Phalangectomy, toe, each toe
28153  Resection, condyle(s), distal end of phalanx, each toe
28160  Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each
28171  Radical resection of tumor; tarsal (except talus or calcaneus)
28173  metatarsal
28175  phalanx of toe

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

REPAIR, REVISION, AND/OR RECONSTRUCTION
28200  Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon
28202  secondary with free graft, each tendon (includes obtaining graft)
28208  Repair, tendon, extensor, foot; primary or secondary, each tendon
28210  secondary with free graft, each tendon (includes obtaining graft)
28220  Tenolysis, flexor, foot; single tendon
28222  multiple tendons
28225  Tenolysis, extensor, foot; single tendon
28226  multiple tendons
28230  Tenotomy, open, tendon flexor; foot, single or multiple tendon(s) (separate procedure)
28232  toe, single tendon (separate procedure)
28234 Tenotomy, open, extensor, foot or toe, each tendon
28238 Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)
28240 Tenotomy lengthening, or release, abductor hallucis muscle
28250Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure)
28260 Capsulotomy, midfoot; medial release only (separate procedure)
28261 with tendon lengthening
28262 extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)
28264 Capsulotomy, midtarsal (eg, Heyman type procedure)
28270 Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)
28272 interphalangeal joint, each joint (separate procedure)
28280 Syndactylization, toes (eg, webbing or Kelikian type procedure)
28285 Correction, hammertoe; (eg, interphalangeal fusion, partial or total phalangectomy)
28286 Correction, cock-up fifth toe, with plastic skin closure (Ruiz-Mora type procedure)
28288 Osteotomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head
28289 Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant
28291 with implant
28292 Correction, hallux valgus (bunionectomy), with sesamoidectomy when performed; with resection of proximal phalanx base, when performed, any method
28296 with distal metatarsal osteotomy, any method
28295 with proximal metatarsal osteotomy, any method
28297 with first metatarsal and medical cuneiform joint arthrodesis, any method
28298 with proximal phalanx osteotomy, any method
28299 with double osteotomy, any method
28300 Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation
28302 talus
28304 Osteotomy, tarsal bones, other than calcaneus or talus;
28305 with autograft (includes obtaining graft) (eg, Fowler type)
28306 Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal
28307 first metatarsal with autograft (other than first toe)
28308 other than first metatarsal, each
28309 multiple, (eg, Swanson type cavus foot procedure)
28310 Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
28312 other phalanges, any toe
28313 Reconstruction, angular deformity of toe, soft tissue procedures only (overlapping second toe, fifth toe, curly toes)
28315 Sesamoidectomy, first toe (separate procedure)
28320 Repair of nonunion or malunion; tarsal bones
28322 metatarsal, with or without bone graft (includes obtaining graft)
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<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>Procedure 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, each</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>
<tr>
<td>28555</td>
<td>Open treatment of tarsal bone dislocation, includes internal fixation, when performed</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>28570</td>
<td>Closed treatment of talotarsal joint dislocation; without anesthesia</td>
</tr>
<tr>
<td>28575</td>
<td>requiring anesthesia</td>
</tr>
<tr>
<td>28576</td>
<td>Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation</td>
</tr>
<tr>
<td>28585</td>
<td>Open treatment of talotarsal joint dislocation, includes internal fixation, when performed</td>
</tr>
<tr>
<td>28600</td>
<td>Closed treatment of tarsometatarsal joint dislocation; without anesthesia</td>
</tr>
<tr>
<td>28605</td>
<td>requiring anesthesia</td>
</tr>
<tr>
<td>28606</td>
<td>Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation</td>
</tr>
<tr>
<td>28615</td>
<td>Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed</td>
</tr>
<tr>
<td>28630</td>
<td>Closed treatment of metatarsophalangeal joint dislocation; without anesthesia</td>
</tr>
<tr>
<td>28635</td>
<td>requiring anesthesia</td>
</tr>
<tr>
<td>28636</td>
<td>Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation</td>
</tr>
<tr>
<td>28645</td>
<td>Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed</td>
</tr>
<tr>
<td>28660</td>
<td>Closed treatment of interphalangeal joint dislocation; without anesthesia</td>
</tr>
<tr>
<td>28665</td>
<td>requiring anesthesia</td>
</tr>
<tr>
<td>28666</td>
<td>Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation</td>
</tr>
<tr>
<td>28675</td>
<td>Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed</td>
</tr>
</tbody>
</table>

**ARTHRODESIS**

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

**AMPUTATION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>28800</td>
<td>Amputation, foot; midtarsal (eg, Chopart type procedure)</td>
</tr>
<tr>
<td>28805</td>
<td>transmetatarsal</td>
</tr>
<tr>
<td>28810</td>
<td>Amputation, metatarsal, with toe, single</td>
</tr>
<tr>
<td>28820</td>
<td>Amputation, toe; metatarsophalangeal joint</td>
</tr>
<tr>
<td>28825</td>
<td>interphalangeal joint</td>
</tr>
</tbody>
</table>

**OTHER PROCEDURES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>28899</td>
<td>Unlisted procedure, foot or toes</td>
</tr>
</tbody>
</table>
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 acromioplasty, with coracoacromial ligament (ie, arch) release, when performed
(List separately in addition to primary procedure)
Use 29826 in conjunction with 29806-29825, 29827, 29828)
29827  with rotator cuff
29828  Arthroscopy, shoulder, surgical; biceps tenodesis
         (Do not report 29828 in conjunction with 29805, 29820, 29822)
29830  Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
29834  Arthroscopy, elbow, surgical; with removal of loose body or foreign body
29835  synovectomy, partial
29836  synovectomy, complete
29837  debridement, limited
29838  debridement, extensive
29840  Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)
29843  Arthroscopy, wrist, surgical; for infection, lavage and drainage
29844  synovectomy, partial
29845  synovectomy, complete
29846  excision and/or repair of triangular fibrocartilage and/or joint debridement
29847  internal fixation for fracture or instability
29848  Endoscopy, wrist, surgical, with release of transverse carpal ligament
29850  Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)
29851  with internal or external fixation (includes arthroscopy)
29855  Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicompartmental, includes internal fixation, when performed (includes arthroscopy)
29856  bicondylar, includes internal fixation, when performed (includes arthroscopy)
29860  Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)
29861  Arthroscopy, hip, surgical; with removal of loose body or foreign body
29862  with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
29863  with synovectomy
29866  Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])
         (Do not report 29866 in conjunction with 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)
29867  osteochondral allograft (eg, mosaicplasty)
         (Do not report 29867 in conjunction with 27570, 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)
         (Do not report 29867 in conjunction with 27415)
29868  meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
         (Do not report 29868 in conjunction with 29870, 29871, 29875, 29880, 29883, 29884 when performed at the same session or 29874, 29877, 29881, 29882 when performed in the same compartment)
29870  Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29871  Arthroscopy, knee, surgical; for infection, lavage and drainage
29873  with lateral release
29874 for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)
29875 synovectomy, limited (eg, plica or shelf resection) (separate procedure)
29876 synovectomy, major, two or more compartments (eg, medial or lateral)
29877 debridement/shaving of articular cartilage (chondroplasty)
29879 abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
29880 with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29881 with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29882 with meniscus repair (medial or lateral)
29883 with meniscus repair (medial and lateral)
29884 with lysis of adhesions with or without manipulation (separate procedure)
29885 drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)
29886 drilling for intact osteochondritis dissecans lesion
29887 drilling for intact osteochondritis dissecans lesion with internal fixation
29888 Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29889 Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction (Procedures 29888 and 29889 should not be used with reconstruction procedures 27427-27429)
29891 Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and/or tibia, including drilling of the defect
29892 Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)
29893 Endoscopic plantar fasciotomy
29894 Arthroscopy ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body
29895 synovectomy, partial
29897 debridement, limited
29898 debridement, extensive
29899 with ankle arthrodesis
29900 Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy (Do not report 29900 with 29901, 29902)
29901 Arthroscopy, metacarpophalangeal joint, surgical; with debridement
29902 with reduction of displaced ulnar collateral ligament (eg, Stener Lesion)
29904 Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body
29905 Arthroscopy, subtalar joint, surgical; with synovectomy
29906 Arthroscopy, subtalar joint, surgical; with debridement
29907 Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis
29914 Arthroscopy, hip, surgical; with removal of loose body or foreign body with femoroplasty (ie., treatment of cam lesion)
29915  with acetabuloplasty (ie, treatment of pincer lesion)
(Do not report 29914, 29915 in conjunction with 29862, 29863)
29916  with labral repair
(Do not report 29916 for labral repair secondary to acetabuloplasty or in conjunction
with 29862, 29863)
29999  Unlisted procedure, arthroscopy

**RESPIRATORY SYSTEM**

**NOSE**

**INCISION**

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

**EXCISION**

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

**INTRODUCTION**

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

**REMOVAL OF FOREIGN BODY**

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

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

30410 complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip

30420 including major septal repair

30430 Rhinoplasty, secondary; minor revision (small amount of nasal tip work)

30435 intermediate revision (bony work with osteotomies)

30450 major revision (nasal tip work and osteotomies)

30460 Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only

30462 tip, septum, osteotomies

30465 Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)

(30465 excludes obtaining graft. For graft procedure, see 20900-20926, 21210)

(30465 is used to report a bilateral procedure)

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

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

OTHER PROCEDURES

31299  Unlisted procedure, accessory sinuses

LARYNX

EXCISION

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

INTRODUCTION

31500 Intubation, endotracheal, emergency procedure

ENDOSCOPY

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

31505 Laryngoscopy, indirect; diagnostic (separate procedure)
31510 with biopsy
31511 with removal of foreign body
31512 with removal of lesion
31513 with vocal cord injection
31515 Laryngoscopy, direct, with or without tracheoscopy; for aspiration
31520 diagnostic, newborn
(Do not report 31520 with modifier –63)
31525 diagnostic, except newborn
31526 diagnostic, with operating microscope or telescope
31527 with insertion of obturator
31528 with dilation, initial
31529 with dilation, subsequent
31530 Laryngoscopy, direct, operative, with foreign body removal;
31531 with operating microscope or telescope
31535 Laryngoscopy, direct, operative, with biopsy;
31536 with operating microscope or telescope
31540 Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis;
31541 with operating microscope or telescope
31545 Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)
31546 reconstruction with graft(s) (includes obtaining autograft)
(Do not report 31546 in addition to 20926 for graft harvest)
(Do not report 31545 or 31546 in conjunction with 31540, 31541)
31560 Laryngoscopy, direct, operative, with arytenoidectomy;
31561 with operating microscope or telescope
31570 Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;
31571 with operating microscope or telescope
31575 Laryngoscopy, flexible; diagnostic
31576 with biopsy(ies)
31577 with removal of foreign body(s)
31578 with removal of lesion(s), non-laser
31572 with ablation or destruction of lesion(s) with laser, unilateral
31573 with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral
31574 with injection(s) for augmentation (eg, percutaneous, transoral), unilateral
31579 Laryngoscopy, flexible or rigid telescopic, with stroboscopy

REPAIR

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

DESTRUCTION

OTHER PROCEDURES

31599 Unlisted procedure, larynx

TRACHEA AND BRONCHI

INCISION

31600 Tracheostomy, planned (separate procedure);
31601 under two years
31603 Tracheostomy, emergency procedure; transtracheal
31605 cricothyroid membrane
31610 Tracheostomy, fenestration procedure with skin flaps
31611 Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)
31612 Tracheal puncture, percutaneous with transtracheal aspiration and/or injection
31613 Tracheostoma revision; simple, without flap rotation
31614 complex, with flap rotation

ENDOSCOPY

Version 2020
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
Physician - Procedure Codes, Section 5 - Surgery

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
       bronchoscopy 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); nasotracheal
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
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>32480</td>
<td>Removal of lung, other than pneumonectomy; single lobe (lobectomy)</td>
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<tr>
<td>32482</td>
<td>2 lobes (bilobectomy)</td>
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<tr>
<td>32484</td>
<td>single segment (segmentectomy)</td>
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<tr>
<td>32486</td>
<td>with circumferential resection of segment of bronchus followed by broncho bronchial-anastomosis (sleeve lobectomy)</td>
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<tr>
<td>32488</td>
<td>with all remaining lung following previous removal of a portion of lung (completion pneumonectomy)</td>
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<tr>
<td>32491</td>
<td>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</td>
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<tr>
<td>32501</td>
<td>Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to primary procedure)</td>
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<tr>
<td></td>
<td>(Use 32501 in conjunction with codes 32480, 32482, 32484)</td>
</tr>
<tr>
<td></td>
<td>(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)</td>
</tr>
<tr>
<td>32503</td>
<td>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)</td>
</tr>
<tr>
<td>32504</td>
<td>with chest wall reconstruction (Do not report 32503, 32504 in conjunction with 19260, 19271, 19272, 32100, 32551)</td>
</tr>
<tr>
<td>32505</td>
<td>Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial (Do not report 32505 in conjunction with 32440, 32442, 32445, 32488)</td>
</tr>
<tr>
<td>32506</td>
<td>with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Report 32506 only in conjunction with 32505)</td>
</tr>
<tr>
<td>32507</td>
<td>with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Report 32507 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504)</td>
</tr>
<tr>
<td>32540</td>
<td>Extrapleural enucleation of empyema (empyemectomy);</td>
</tr>
</tbody>
</table>

**INTRODUCTION AND REMOVAL**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>32550</td>
<td>Insertion of indwelling tunneled pleural catheter with cuff (Do not report 32550 in conjunction with 32554, 32555)</td>
</tr>
<tr>
<td>32551</td>
<td>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, 32503, 32504)</td>
</tr>
<tr>
<td>32552</td>
<td>Removal of indwelling tunneled pleural catheter with cuff</td>
</tr>
<tr>
<td>32553</td>
<td>Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple (Report supply of device separately)</td>
</tr>
<tr>
<td>32554</td>
<td>Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance</td>
</tr>
<tr>
<td>32555</td>
<td>with imaging guidance</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<td>--------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>32556</td>
<td>Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance</td>
</tr>
<tr>
<td>32557</td>
<td>with imaging guidance</td>
</tr>
<tr>
<td></td>
<td><strong>DESTRUCTION</strong></td>
</tr>
<tr>
<td>32560</td>
<td>Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)</td>
</tr>
<tr>
<td>32561</td>
<td>Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day</td>
</tr>
<tr>
<td></td>
<td>subsequent day</td>
</tr>
<tr>
<td></td>
<td><strong>ENDOSCOPY</strong></td>
</tr>
<tr>
<td></td>
<td>Surgical thoracoscopy always includes diagnostic thoracoscopy.</td>
</tr>
<tr>
<td></td>
<td>For endoscopic procedures, code appropriate endoscopy of each anatomic site examined.</td>
</tr>
<tr>
<td>32601</td>
<td>Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without biopsy</td>
</tr>
<tr>
<td>32604</td>
<td>pericardial sac, with biopsy</td>
</tr>
<tr>
<td>32606</td>
<td>mediastinal space, with biopsy</td>
</tr>
<tr>
<td>32607</td>
<td>Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral</td>
</tr>
<tr>
<td></td>
<td>(Do not report 32607 in conjunction with 32440, 32442, 32445, 32488, 32671)</td>
</tr>
<tr>
<td>32608</td>
<td>with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral</td>
</tr>
<tr>
<td></td>
<td>(Do not report 32608 in conjunction with 32440, 32442, 32445, 32488, 32671)</td>
</tr>
<tr>
<td>32609</td>
<td>with biopsy(ies) of pleura</td>
</tr>
<tr>
<td>32650</td>
<td>Thoracoscopy, surgical; with pleurodesis, (eg, mechanical or chemical)</td>
</tr>
<tr>
<td>32651</td>
<td>with partial pulmonary decortication</td>
</tr>
<tr>
<td>32652</td>
<td>with total pulmonary decortication, including intrapleural pneumonolysis</td>
</tr>
<tr>
<td>32653</td>
<td>with removal of intrapleural foreign body or fibrin deposit</td>
</tr>
<tr>
<td>32654</td>
<td>with control of traumatic hemorrhage</td>
</tr>
<tr>
<td>32655</td>
<td>with resection-plication of bullae, includes any pleural procedure when performed</td>
</tr>
<tr>
<td>32656</td>
<td>with parietal pleurectomy</td>
</tr>
<tr>
<td>32658</td>
<td>with removal of clot or foreign body from pericardial sac</td>
</tr>
<tr>
<td>32659</td>
<td>with creation of pericardial window or partial resection of pericardial sac for drainage</td>
</tr>
<tr>
<td>32661</td>
<td>with excision of pericardial cyst, tumor, or mass</td>
</tr>
<tr>
<td>32662</td>
<td>with excision of mediastinal cyst, tumor, or mass</td>
</tr>
<tr>
<td>32663</td>
<td>with lobectomy (single lobe)</td>
</tr>
<tr>
<td>32664</td>
<td>with thoracic sympathectomy</td>
</tr>
<tr>
<td>32665</td>
<td>with esophagomyotomy (Heller type)</td>
</tr>
<tr>
<td>32666</td>
<td>with therapeutic wedge resection (eg, mass, nodule), initial unilateral</td>
</tr>
<tr>
<td>32667</td>
<td>with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary code)</td>
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<tr>
<td></td>
<td>(Report 32667 only in conjunction with 32666)</td>
</tr>
<tr>
<td>32668</td>
<td>with diagnostic wedge resection followed by anatomic lung resection</td>
</tr>
</tbody>
</table>
(List separately in addition to primary code)
(Report 32668 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32663, 32669, 32670, 32671)

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

STEREOTACTIC RADIATION THERAPY

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

REPAIR

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

LUNG TRANSPLANTATION

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

SURGICAL COLLAPSE THERAPY; THORACOPLASTY

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

OTHER PROCEDURES

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

**CARDIOVASCULAR SYSTEM**

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

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

**HEART AND PERICARDIUM**

**PERICARDIUM**

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

**CARDIAC TUMOR**

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

**TRANSMYOCARDIAL REVASCULARIZATION**

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

**PACE MAKER 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 thorascoscopic 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 Insertion of epicardial electrode(s); 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
ventricular
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
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

33235 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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33250</td>
<td>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</td>
</tr>
<tr>
<td>33251</td>
<td>with cardiopulmonary bypass</td>
</tr>
<tr>
<td>33254</td>
<td>Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)</td>
</tr>
<tr>
<td>33255</td>
<td>Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass</td>
</tr>
<tr>
<td>33256</td>
<td>with cardiopulmonary bypass</td>
</tr>
<tr>
<td>33257</td>
<td>Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure)</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td>33258</td>
<td>Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td>33259</td>
<td>Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td>33261</td>
<td>Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass</td>
</tr>
<tr>
<td>33263</td>
<td>dual lean system</td>
</tr>
<tr>
<td>33264</td>
<td>multiple lead system</td>
</tr>
</tbody>
</table>

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

SUBCUTANEOUS CARDIAC RHYTHM MONITOR

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

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

WOUNDS OF THE HEART AND GREAT VESSELS

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

CARDIAC VALVES

33361  Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
33362  open femoral artery approach
33363  open axillary artery approach
33364  open iliac artery approach
33365  transaortic approach (eg, median sternotomy, mediastinotomy)
33366  transapical exposure (eg, left thoracotomy)
33367  cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels)  
(List separately in addition to primary procedure)
33368  cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels)  
(List separately in addition to primary procedure)
33369  cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery)  
(List separately in addition to primary procedure)

33390  Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple (ie, valvotomy, debridement, debulking, and/or simple commissural resuspension)

33391  complex (eg, leaflet extension, leaflet resection, leaflet reconstruction, or annuloplasty)

AORTIC VALVE

33404  Construction of apical-aortic conduit

33405  Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

33406  with allograft valve (freehand)

33410  with stentless tissue valve

33440  Replacement, aortic valve; by translocation of autologous pulmonary valve and transventricular aortic annulus enlargement of the left ventricular outflow tract with valved conduit replacement of pulmonary valve (Ross-Konno procedure)

33411  Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus

33412  with transventricular aortic annulus enlargement (Konno procedure)

33413  by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)

33414  Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract

33415  Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis

33416  Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy)

33417  Aortoplasty (gusset) for supravalvular stenosis

MITRAL VALVE

33418  Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis

33419  additional prosthesis(es) during same session (List separately in addition to code for primary procedure)

33420  Valvotomy, mitral valve; closed heart

33422  open heart, with cardiopulmonary bypass

33425  Valvuloplasty, mitral valve, with cardiopulmonary bypass; 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)
33518 two venous grafts
  (List separately in addition to primary procedure)
  (Use 33518 in conjunction with 33533-33536)
33519 three venous grafts
  (List separately in addition to primary procedure)
  (Use 33519 in conjunction with 33533-33536)
33521 four venous grafts
  (List separately in addition to primary procedure)
  (Use 33521 in conjunction with 33533-33536)
33522 five venous grafts
  (List separately in addition to primary procedure)
(Use 33522 in conjunction with 33533-33536)

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

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

**ARTERIAL GRAFTING FOR CORONARY ARTERY BYPASS**

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

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

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

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

**CORONARY ENDARTERECTOMY**

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

**SINGLE VENTRICLE AND OTHER COMPLEX CARDIAC ANOMALIES**
(Do not report modifier –63 in conjunction with 33610, 33611 or 33619)

33600 Closure of atrioventricular valve (mitral or tricuspid) by suture or patch
33602 Closure of semilunar valve (aortic or pulmonary) by suture or patch
33606 Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure)
33608 Repair of complex cardiac anomaly other than pulmonary atresia with ventricular septal defect by construction or replacement of conduit from right or left ventricle to pulmonary artery
33610 Repair of complex cardiac anomalies (eg, single ventricle with subaortic obstruction) by surgical enlargement of ventricular septal defect
33611 Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction
33615 Repair of complex cardiac anomalies (eg, tricuspid atresia) by closure of atrial septal defect and anastomosis of atria or vena cava to pulmonary artery (simple Fontan procedure)
33617 Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure
33619 Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)
33620 Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)
33621 Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)
33622 Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary artery bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding) (Do not report 33622 in conjunction with 33619, 33676, 33682, 33840, 33845, 33851, 33853, 33917)

SEPTAL DEFECT

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

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

SINUS OF VALSALVA

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

VENOUS ANOMALIES

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

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

SHUNTING PROCEDURES

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

33735 Atrial septectomy or septostomy; closed heart (Blalock-Hanlon type operation)
33736 open heart with cardiopulmonary bypass
33737 open heart, with inflow occlusion
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;
    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)
    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
    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)
    with reanastomosis
33813  Obliteration of aortopulmonary septal defect; without cardiopulmonary bypass
    with cardiopulmonary bypass
33820  Repair of patent ductus arteriosus; by ligation
    by division, under 18 years
    by division, 18 years and older
33840  Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis
    with graft
33852  Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass
33853  with cardiopulmonary bypass

THORACIC AORTIC ANEURYSM
33858  Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection
33859  for aortic disease other than dissection (eg, aneurysm)
33863  with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)
33864 with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)

33866 Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)

33871 Transverse aortic arch graft, with cardiopulmonary bypass, with profound hypothermia, total circulatory arrest and isolated cerebral perfusion with reimplantation of arch vessel(s) (eg, island pedicle or individual arch vessel reimplantation)

33875 Descending thoracic aorta graft, with or without bypass

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

**ENDOVASCULAR REPAIR OF DESCENDING THORACIC AORTA**

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

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

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

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

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

33883 Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension

(Do not report 33881, 33883 when extension placement converts repair to cover left subclavian origin. use only 33880)
33884 each additional proximal extension
   (List separately in addition to primary procedure)
   (Use 33884 in conjunction with 33883)

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

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

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

**PULMONARY ARTERY**

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

**HEART/LUNG TRANSPLANTATION**

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

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

33946 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous
33947 initiation veno-arterial
33948 daily management, each day, veno-venous
33949 daily management, each day, veno-arterial
33951 insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)
33952 insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)
33953 insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age
33954 insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older
33955 insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age
33956 insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older
33957 reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)
33958 reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)
33959 reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance when performed)
33962 reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)
33963 reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)
33964 reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)
33965 removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age
33966 removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older
33969 removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age
33984 removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older
33985 removal of central cannula(e), by sternotomy or thoracotomy, birth through 5 years of age
33986 removal of central cannula(e), by sternotomy or thoracotomy, 6 years and older
33987 Arterial exposure with creation of graft conduit (eg, chimney graft)
to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)

33988 Insertion of left heart vent by thoracic incision (eg, sternotomy/thoracotomy) for ECMO/ECLS

33989 Removal of left heart vent by thoracic incision (eg, sternotomy/thoracotomy) for ECMO/ECLS

**CARDIAC ASSIST**

33967 Insertion of intra-aortic balloon assist device, percutaneous

33968 Removal of intra-aortic balloon assist device, percutaneous

33970 Insertion of intra-aortic balloon assist device through the femoral artery, open approach

33971 Removal of intra-aortic balloon assist device including repair of femoral artery, with or without graft

33973 Insertion of intra-aortic balloon assist device through the ascending aorta

33974 Removal of intra-aortic balloon assist device from the ascending aorta, including repair of the ascending aorta, with or without graft

33975 Insertion of ventricular assist device; extracorporeal, single ventricle

33976 extracorporeal, biventricular

33977 Removal of ventricular assist device; extracorporeal, single ventricle

33978 extracorporeal, biventricular

33979 Insertion of ventricular assist device, implantable intracorporeal, single ventricle

33980 Removal of ventricular assist device, implantable intracorporeal, single ventricle

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

33982 Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass

33983 with cardiopulmonary bypass

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
surgery, 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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>34001</td>
<td>Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision</td>
</tr>
<tr>
<td>34051</td>
<td>innominate, subclavian artery, by thoracic incision</td>
</tr>
<tr>
<td>34101</td>
<td>axillary, brachial, innominate, subclavian artery, by arm incision</td>
</tr>
<tr>
<td>34111</td>
<td>radial or ulnar artery, by arm incision</td>
</tr>
<tr>
<td>34151</td>
<td>renal, celiac, mesenteric, aortoiliac artery, by abdominal incision</td>
</tr>
<tr>
<td>34201</td>
<td>femoropopliteal, aortoiliac artery, by leg incision</td>
</tr>
<tr>
<td>34203</td>
<td>popliteal-tibio-peroneal, by leg incision</td>
</tr>
</tbody>
</table>

**VENOUS, DIRECT OR WITH CATHETER**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>34401</td>
<td>Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision</td>
</tr>
<tr>
<td>34421</td>
<td>vena cava, iliac, femoropopliteal vein, by leg incision</td>
</tr>
<tr>
<td>34451</td>
<td>vena cava, iliac, femoropopliteal vein, by abdominal and leg incision</td>
</tr>
<tr>
<td>34471</td>
<td>subclavian vein, by neck incision</td>
</tr>
<tr>
<td>34490</td>
<td>axillary and subclavian vein, by arm incision</td>
</tr>
</tbody>
</table>

**VENOUS RECONSTRUCTION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>34501</td>
<td>Valvuloplasty, femoral vein</td>
</tr>
<tr>
<td>34502</td>
<td>Reconstruction of vena cava, any method</td>
</tr>
<tr>
<td>34510</td>
<td>Venous valve transposition, any vein donor</td>
</tr>
<tr>
<td>34520</td>
<td>Cross-over vein graft to venous system</td>
</tr>
<tr>
<td>34530</td>
<td>Saphenopopliteal vein anastomosis</td>
</tr>
</tbody>
</table>

**ENDOVASCULAR REPAIR OF ABDOMINAL AORTA AND/OR Iliac ARTERIES**

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

34704 for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34831 aorto-bi-iliac prosthesis

34832 aorto-bifemoral prosthesis

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

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

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

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)

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

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

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

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

34845 Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, 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])

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

**DIRECT REPAIR OF ANEURYSM OR EXCISION (PARTIAL OR TOTAL) AND GRAFT INSERTION FOR 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
PERCUTANEOUS

BYPASS GRAFT

VEIN

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

35500 Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure
   (List separately in addition to primary procedure)
   (Use 35500 in conjunction with 33510-33536, 35556, 35566, 35571, 35583-35587)
35501 Bypass graft, with vein; common carotid-ipsilateral internal carotid
35506 carotid-subclavian or subclavian-carotid
35508 carotid-vertebral
35509 carotid-contralateral carotid
35510 carotid-brachial
35511 subclavian-subclavian
35512 subclavian-brachial
35515 subclavian-vertebral
35516 subclavian-axillary
35518 axillary-axillary
35521 axillary-femoral
35522 axillary-brachial
35523 brachial-ulnar or -radial
   (Do not report 35523 in conjunction with 35206, 35500, 35525, 36838)
35525 brachial-brachial
35526 aortosubclavian, aortoinnominate, or aortocarotid
35531 aortoceliac or aortomesenteric
35533 axillary-femoral-femoral
35535 hepatorenal
   (Do not report 35535 in conjunction with 35221, 35251, 35281, 35500, 35536, 35560, 35631, 35636)
35536 splenorenal
35537 aortoiliac
   (Do not report 35537 in conjunction with 35538)
35538 aortobi-iliac
(Do not report 35538 in conjunction with 35537)
35539  aortofemoral
(Do not report 35539 in conjunction with 35540)
35540  aortobifemoral
(Do not report 35540 in conjunction with 35539)
35556  femoral-popliteal
35558  femoral-femoral
35560  aortorenal
35563  ilioiliac
35565  iliofemoral
35566  femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels
35570  tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial
(Do not report 35570 in conjunction with 35256, 35286)
35571  popliteal-tibial, -peroneal artery or other distal vessels
35572  Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery)
   (List separately in addition to primary procedure)
   (Use 35572 in conjunction with code 33510-33516, 33517-33523, 33523, 33533-33536, 34502, 34520, 35001, 35002, 35011-35022, 35102, 35103, 35121-35152, 35231-35256, 35501-35587, 35879-35907)
   (For bilateral procedure, use modifier -50)

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

OTHER THAN VEIN
35600  Harvest of upper extremity artery, one segment, for coronary artery bypass procedure
   (List separately in addition to primary procedure)
   (Use 35600 in conjunction with 33533-33536)
35601  Bypass graft, with other than vein; common carotid-ipsilateral internal carotid
35606  carotid-subclavian
35612  subclavian-subclavian
35616  subclavian-axillary
35621  axillary-femoral
35623  axillary-popliteal or -tibial
35626  aortosubclavian, aortoinnominate, or aortocarotid
35631  aortoceliac, aortomesenteric, aortorenal
35632  ilio-cesiack
   (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  iliofemoral
(Do not report 35634 in conjunction with 35221, 35251, 35281, 35560, 35536, 35631)
35636  splenorenal (splenic to renal arterial anastomosis)
35637  aortoiliac
  (Do not report 35637 in conjunction with 35638, 35646)
35638  aortobi-iliac
  (Do not report 35638 in conjunction with 35637, 35646)
35642  carotid-vertebral
35645  subclavian-vertebral
35646  aortobifemoral
35647  aortofemoral
35650  axillary-axillary
35654  axillary-femoral-femoral
35656  femoral-popliteal
35661  femoral-femoral
35663  ilioiliac
35665  iliofemoral
35666  femoral-anterior tibial, posterior tibial, or peroneal artery
35671  popliteal-tibial, or -peroneal artery

**COMPOSITE GRAFTS**

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

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

**ADJUVANT TECHNIQUES**

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

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

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

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

**ARTERIAL TRANSPOSITION**

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

**EXCISION, EXPLORATION, REPAIR, REVISION**

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

35884  with autogenous vein patch graft
(For bilateral procedure, use modifier -50)
(Do not report 35884 in conjunction with 35700, 35875, 35876, 35883)

35901  Excision of infected graft; neck
35903  extremity
35905  thorax
35907  abdomen

VASCULAR INJECTION PROCEDURES

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

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

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

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

INTRA VENOUS

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

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

INTRA ARTERIAL---INTRA -AORTIC

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

   (Do not report 36221 with 36222-36226)
36222  Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
36223  Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
36224  Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
36225  Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
36226  Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
36227  Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation
   (List separately in addition to primary procedure)
   (Use 36227 in conjunction with 36222, 36223, or 36224)
36228  Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery)
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
(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)
(bilateral

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

36261
Revision of implanted intra-arterial infusion pump

36262
Removal of implanted intra-arterial infusion pump

36299
Unlisted procedure, vascular injection

VENOUS

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

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

36400
Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein

36405
scalp vein

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

36420 Venipuncture, cutdown; younger than age 1 year

36425 age 1 or over (Not to be used for routine venipuncture)

36430 Transfusion, blood or blood components

36440 Push transfusion, blood, 2 years or younger

36450 Exchange transfusion, blood; newborn

36455 other than newborn

36456 Partial exchange transfusion, blood, plasma or crystalloid necessitating the skill of a physician or other qualified healthcare professional, newborn

36460 Transfusion, intrauterine, fetal

36468 Injection(s) of sclerosant for spider veins (telangiectasia); limb or trunk

36470 Injection of sclerosant; single incompetent vein (other than telangiectasia)

36471 multiple incompetent veins (other than telangiectasia), same leg

36465 Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)

36466 multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg

36475 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated

36476 subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

(Use 36476 in conjunction with 36475)

36478 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated

36479 subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

(Use 36479 in conjunction with 36478)

36478, 36479 are an alternative to standard open stripping and ligation procedure, covered for refractory leg ulcers due to saphenous vein incompetence, or recurrent or significant bleeding from a varicosity.

36481 Percutaneous portal vein catheterization by any method

36500 Venous catheterization for selective organ blood sampling

36510 Catheterization of umbilical vein for diagnosis or therapy, newborn

36511 Therapeutic apheresis; for white blood cells

36512 for red blood cells

36513 for platelets

36514 for plasma pheresis

36516 with extracorporeal immunoadsorption, selective absorption or selective filtration and plasma reinfusion

36522 Photopheresis, extracorporeal
CENTRAL VENOUS ACCESS PROCEDURES

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

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

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

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

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

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

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

INSERTION OF CENTRAL VENOUS ACCESS DEVICE

36555  Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age
36556   age 5 years or older
36557  Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age
36558   age 5 years or older
36560  Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; under 5 years of age
36561   age 5 years or older
36563  Insertion of tunneled centrally inserted central venous access device with subcutaneous pump
36565  Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)
36566   with subcutaneous port(s)
36568  Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age
36569  age 5 years or older
36572  Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age
36573  age 5 years or older
36570  Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age
36571  age 5 years or older

REPAIR OF CENTRAL VENOUS ACCESS DEVICE

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

PARTIAL REPLACEMENT OF CENTRAL VENOUS ACCESS DEVICE (CATHETER ONLY)

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

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

36580  Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36581  Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36582  Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access
36583  Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access
36584  Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and 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
36625 cutdown
36640 Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown
(See also 96420-96425)
36660 Catheterization, umbilical artery, newborn, for diagnosis or therapy
(Do not report modifier 63 in conjunction with 36660)

INTRAOSSEOUS

36680 Placement of needle for intraosseous infusion

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

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

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

DIALYSIS CIRCUIT

36901 Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis 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 through 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
   each additional artery (List separately in addition to code for primary procedure)
37247  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
   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
   each additional artery (List separately in addition to code for primary procedure)
37237  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
   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, intraprocedural 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, inguinofemoral node(s)
38542  Dissection, deep jugular node(s)
38550  Excision of cystic hydromel, axillary or cervical; without deep neurovascular dissection
38555  with deep neurovascular dissection

**LIMITED LYMPHADENECTOMY FOR STAGING**

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

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

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

**RADICAL LYMPHADENECTOMY (RADICAL RESECTION OF LYMPH NODES)**

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

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

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

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

**INTRODUCTION**

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

38792 Radioactive tracer for identification of sentinel node

38794 Cannulation, thoracic duct

**OTHER PROCEDURES**

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

38999 Unlisted procedure, hemic or lymphatic system

**MEDIASTINUM AND DIAPHRAGM**

**MEDIASTINUM**

**INCISION**

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

39010 Transthoracic approach, including either transthoracic or median sternotomy

**EXCISION/RESECTION**

39200 Resection of mediastinal cyst

39220 Resection of mediastinal tumor

**ENDOSCOPY**

39401 Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed

39402 with lymph node biopsy(ies) (eg, lung cancer staging)

**OTHER PROCEDURES**

39499 Unlisted procedure, mediastinum

**DIAPHRAGM**
REPAIR

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

OTHER PROCEDURES

39599 Unlisted procedure, diaphragm

DIGESTIVE SYSTEM

LIPS

EXCISION

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

REPAIR (CHEILOPLASTY)

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

OTHER PROCEDURES

40799 Unlisted procedure, lips
VESTIBULE OF MOUTH

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

INCISION

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>40800</td>
<td>Drainage of abscess, cyst, hematoma, vestibule of mouth; simple</td>
</tr>
<tr>
<td>40801</td>
<td>complicated</td>
</tr>
<tr>
<td>40804</td>
<td>Removal of embedded foreign body; vestibule of mouth; simple</td>
</tr>
<tr>
<td>40805</td>
<td>complicated</td>
</tr>
<tr>
<td>40806</td>
<td>Incision of labial frenum (frenotomy)</td>
</tr>
</tbody>
</table>

EXCISION, DESTRUCTION

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

REPAIR

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>40830</td>
<td>Closure of laceration, vestibule of mouth; 2.5 cm or less</td>
</tr>
<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>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>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>
</tbody>
</table>
Physician - Procedure Codes, Section 5 - Surgery

41010 Incision of lingual frenum (frenotomy)
41015 Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual
submental
submandibular
masticator space
41019 Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application

EXCISION

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

REPAIR

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

OTHER PROCEDURES

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

DENTOALVEOLAR STRUCTURES
INCISION

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

EXCISION, DESTRUCTION

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

OTHER PROCEDURES

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

PALATE AND UVULA

INCISION

42000 Drainage of abscess of palate, uvula

EXCISION, DESTRUCTION

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

REPAIR

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

OTHER PROCEDURES
42299  Unlisted procedure, palate, uvula

SALIVARY GLANDS AND DUCTS

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

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

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

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

PHARYNX, ADENOIDS, AND TONSILS

INCISION

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

EXCISION, DESTRUCTION

42800 Biopsy; oropharynx
42804 nasopharynx, visible lesion, simple
42806 nasopharynx, survey for unknown primary lesion
42808 Excision or destruction of lesion of pharynx, any method
42809 Removal of foreign body from pharynx
42810 Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues
42815 Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues
and/or into pharynx
42820 Tonsillectomy and adenoidectomy; under age 12
42821 age 12 or over
42825 Tonsillectomy, primary or secondary; under age 12
42826 age 12 or over
42830 Adenoidectomy, primary; under age 12
42831 age 12 or over
42835 Adenoidectomy, secondary; under age 12
42836 age 12 or over
42842 Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure
42844 closure with local flap (eg, tongue, buccal)
42845 closure with other flap
42860 Excision of tonsil tags
42870 Excision or destruction lingual tonsil, any method (separate procedure)
42890 Limited pharyngectomy
42892 Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of
lateral and posterior pharyngeal walls
42894 Resection of pharyngeal wall requiring closure with myocutaneous or fasciocutaneous flap or
free muscle, skin, or fascial flap with microvascular anastomosis

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

OTHER PROCEDURES

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

ESOPHAGUS

INCISION

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

EXCISION

43100  Excision of lesion, esophagus, with primary repair; cervical approach
43101   thoracic or abdominal approach
43107  Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)
43108   with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)
43112  Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (ie, McKeown esophagectomy or tri-incisional esophagectomy)
43113   with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43116  Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction
43117  Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)
43118   with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43121  Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty
43122 Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty
43123 with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43124 Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy
43130 Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach 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  Esophagastroduodenoscopy, 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 transendoscopic balloon dilation of esophagus (less than 30 mm diameter)
43233  with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)
43250  with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
43251  with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43252  with optical endomicroscopy
43253  with transendoscopic ultrasound-guided transmural injection or diagnostic or therapeutic substances(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the 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)
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

43310 Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula

43312 with repair of tracheoesophageal fistula

43313 Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach, without repair of congenital tracheoesophageal fistula

43314 with repair of congenital tracheoesophageal fistula  
(Do not report modifier –63 in conjunction with 43313, 43314)

43320 Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach

43325 Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)

43327 Esophagogastric fundoplasty partial or complete; laparotomy

43328 thoracotomy

43330 Esophagomyotomy (Heller type); abdominal approach

43331 thoracic approach

43332 Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis

43333 with implantation of mesh or other prosthesis

43334 Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis

43335 with implantation of mesh or other prosthesis
43336 Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis
43337 with implantation of mesh or other prosthesis
43338 Esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to primary procedure) (Use 43338 in conjunction with 43280, 43327-43337)
43340 Esophagojejunostomy (without total gastrectomy); abdominal approach
43341 thoracic approach
43351 Esophagostomy, fistulization of esophagus, external; thoracic approach
43352 cervical approach
43360 Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty
43361 with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43400 Ligation, direct, esophageal varices
43405 Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation
43410 Suture of esophageal wound or injury; cervical approach
43415 transthoracic or transabdominal approach
43420 Closure of esophagostomy or fistula; cervical approach
43425 transthoracic or transabdominal approach

MANIPULATION

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

OTHER PROCEDURES

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

STOMACH

INCISION

43500 Gastrotomy; with exploration or foreign body removal
43501 with suture repair of bleeding ulcer
43502 with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss)
43510 with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin)
43520 Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation) (Do not report modifier 63 in conjunction with 43520)
43605 Biopsy of stomach, by laparotomy
43610 Excision, local; ulcer or benign tumor of stomach
43611 malignant tumor of stomach
43620 Gastrectomy, total; with esophagoenterostomy
43621 with Roux-en-Y reconstruction
43622 with formation of intestinal pouch, any type
43631 Gastrectomy, partial, distal; with gastroduodenostomy
43632 with gastrojejunostomy
43633 with Roux-en-Y reconstruction
43634 with formation of intestinal pouch
43635 Vagotomy when performed with partial distal gastrectomy
(List separately in addition to code(s) for primary procedure)
(Use 43635 in conjunction with 43631, 43632, 43633, 43634)
43640 Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective
43641 parietal cell (highly selective)

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

43644 Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
(Do not report 43644 in conjunction with 43846, 49320)
43645 with gastric bypass and small intestine reconstruction to limit absorption
(Do not report 43645 in conjunction with 49320, 43847)
43647 Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648 revision or removal of gastric neurostimulator electrodes, antrum
43651 Laparoscopy, surgical; transection of vagus nerves, truncal
43652 transection of vagus nerves, selective or highly selective
43653 gastrostomy, without construction of gastric tube (eg, Stamm procedure) (separate procedure)
43659 Unlisted laparoscopy procedure, stomach

**INTRODUCTION**

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

43756  Duodenal intubation and aspiration, diagnostic, includes image guidance; single specimen (eg, bile study for crystals or afferent loop culture)

43757  collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration

43761  Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition 
(Do not report 43761 in conjunction with 44500, 49446)

43762  Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract

43763  requiring revision of gastrostomy tract

BARIATRIC SURGERY

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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

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

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

43771  revision of adjustable gastric restrictive device component only

43772  removal of adjustable gastric restrictive component only

43773  removal and replacement of adjustable gastric restrictive device component only 
(Do not report 43773 in conjunction with 43772)

43774  removal of adjustable gastric restrictive device and subcutaneous port components

43775  longitudinal gastrectomy (ie, sleeve gastrectomy)

OTHER PROCEDURES

43800  Pyloroplasty

43810  Gastroduodenostomy

43820  Gastrojejunostomy; without vagotomy

43825  with vagotomy, any type

43830  Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)

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

INTESTINES (EXCEPT RECTUM)

INCISION

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

**EXCISION**

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

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

44111 multiple enterotomies

44120 Enterectomy, resection of small intestine; single resection and anastomosis

(Do not report 44120 in addition to 45136)

44121 each additional resection and anastomosis

(List separately in addition to primary procedure)

(Use 44121 in conjunction with 44120)

44125 with enterostomy

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

44127 with tapering

44128 each additional resection and anastomosis

(List separately in addition to primary procedure)

(Use 44128 in conjunction with 44126, 44127)

(Do not report modifier 63 in conjunction with 44126, 44127, 44128)

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

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

44135 Intestinal allotransplantation; from cadaver donor

44136 from living donor

44137 Removal of transplanted intestinal allograft, complete

44139 Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)

(Use 44139 only for codes 44140-44147)

44140 Colectomy, partial; with anastomosis

44141 with skin level cecostomy or colostomy

44143 with end colostomy and closure of distal segment (Hartmann type procedure)

44144 with resection, with colostomy or ileostomy and creation of mucofistula

44145 with coloproctostomy (low pelvic anastomosis)

44146 with coloproctostomy (low pelvic anastomosis), with colostomy

44147 abdominal and transanal approach

44150 Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy

44151 with continent ileostomy

44155 Colectomy, total, abdominal, with proctectomy; with ileostomy

44156 with continent ileostomy

44157 with ileoanal anastomosis, includes loop ileostomy, and rectal mucosextomy, 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44238</td>
<td>Unlisted laparoscopy procedure, intestine (except rectum)</td>
</tr>
</tbody>
</table>

### ENTEROSTOMY - EXTERNAL FISTULIZATION OF INTESTINES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44300</td>
<td>Placement, enterostomy, or cecostomy, tube open (eg, for feeding or decompression) (separate procedure)</td>
</tr>
<tr>
<td>44310</td>
<td>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)</td>
</tr>
<tr>
<td>44312</td>
<td>Revision of ileostomy; simple (release of superficial scar) (separate procedure)</td>
</tr>
<tr>
<td>44314</td>
<td>complicated (reconstruction in depth) (separate procedure)</td>
</tr>
<tr>
<td>44316</td>
<td>Continent ileostomy (Kock procedure) (separate procedure)</td>
</tr>
<tr>
<td>44320</td>
<td>Colostomy or skin level cecostomy; (Do not report 44320 in conjunction with 44141, 44144, 44146, 44605, 45110, 45119, 45126, 45563, 45805, 45825, 50810, 51597, 57307, or 58240)</td>
</tr>
<tr>
<td>44322</td>
<td>with multiple biopsies (eg, for congenital megacolon) (separate procedure)</td>
</tr>
<tr>
<td>44340</td>
<td>Revision of colostomy; simple (release of superficial scar) (separate procedure)</td>
</tr>
<tr>
<td>44345</td>
<td>complicated (reconstruction in depth) (separate procedure)</td>
</tr>
<tr>
<td>44346</td>
<td>with repair of paracolostomy hernia (separate procedure)</td>
</tr>
</tbody>
</table>

### ENDOSCOPY, SMALL INTESTINE AND STOMAL

Surgical endoscopy always includes diagnostic endoscopy.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44360</td>
<td>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)</td>
</tr>
<tr>
<td>44361</td>
<td>with biopsy, single or multiple</td>
</tr>
<tr>
<td>44363</td>
<td>with removal of foreign body(s)</td>
</tr>
<tr>
<td>44364</td>
<td>with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
</tr>
<tr>
<td>44365</td>
<td>with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery</td>
</tr>
<tr>
<td>44366</td>
<td>with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)</td>
</tr>
<tr>
<td>44369</td>
<td>with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</td>
</tr>
<tr>
<td>44370</td>
<td>with transendoscopic stent placement (includes predilation)</td>
</tr>
<tr>
<td>44372</td>
<td>with placement of percutaneous jejunostomy tube</td>
</tr>
<tr>
<td>44373</td>
<td>with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube</td>
</tr>
<tr>
<td>44376</td>
<td>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)</td>
</tr>
<tr>
<td>44377</td>
<td>with biopsy, single or multiple</td>
</tr>
</tbody>
</table>
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)
44381  with biopsy, single or multiple
44382  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-dilation 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
44950  Appendectomy;
   (Incidental appendectomy during intra-abdominal surgery does not warrant a separate
   identification)
44955  when done for indicated purpose at time of other major procedure (not as separate
   procedure)
   (List separately in addition to primary procedure)
44960  for ruptured appendix with abscess or generalized peritonitis

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

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

**RECTUM**

**INCISION**

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

**EXCISION**

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

**DESTRUCTION**

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

**ENDOSCOPY**

**DEFINITIONS:**

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

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

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

(Surgical endoscopy always includes diagnostic endoscopy)

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45395</td>
<td>Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy</td>
</tr>
<tr>
<td>45397</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>
</tbody>
</table>

**REPAIR**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45400</td>
<td>Laparoscopy, surgical; proctopexy (for prolapse)</td>
</tr>
<tr>
<td>45402</td>
<td>Proctopexy (for prolapse), with sigmoid resection</td>
</tr>
<tr>
<td>45499</td>
<td>Unlisted laparoscopy procedure, rectum</td>
</tr>
<tr>
<td>45500</td>
<td>Proctoplasty; for stenosis</td>
</tr>
<tr>
<td>45505</td>
<td>For prolapse of mucous membrane</td>
</tr>
<tr>
<td>45520</td>
<td>Perirectal injection of sclerosing solution for prolapse</td>
</tr>
<tr>
<td>45540</td>
<td>Proctopexy (eg, for prolapse); abdominal approach</td>
</tr>
<tr>
<td>45541</td>
<td>Perineal approach</td>
</tr>
<tr>
<td>45550</td>
<td>With sigmoid resection, abdominal approach</td>
</tr>
<tr>
<td>45560</td>
<td>Repair of rectocele (separate procedure)</td>
</tr>
<tr>
<td>45562</td>
<td>Exploration, repair, and presacral drainage for rectal injury;</td>
</tr>
<tr>
<td>45563</td>
<td>With colostomy</td>
</tr>
<tr>
<td>45800</td>
<td>Closure of rectovesical fistula;</td>
</tr>
<tr>
<td>45805</td>
<td>With colostomy</td>
</tr>
<tr>
<td>45820</td>
<td>Closure of rectourethral fistula;</td>
</tr>
<tr>
<td>45825</td>
<td>With colostomy</td>
</tr>
</tbody>
</table>

**MANIPULATION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45900</td>
<td>Reduction of procidentia (separate procedure) under anesthesia</td>
</tr>
<tr>
<td>45905</td>
<td>Dilation of anal sphincter (separate procedure) under anesthesia other than local</td>
</tr>
<tr>
<td>45910</td>
<td>Dilation of rectal stricture (separate procedure) under anesthesia other than local</td>
</tr>
<tr>
<td>45915</td>
<td>Removal of fecal impaction or foreign body (separate procedure) under anesthesia</td>
</tr>
</tbody>
</table>

**OTHER PROCEDURES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45399</td>
<td>Unlisted procedure, colon</td>
</tr>
<tr>
<td>45999</td>
<td>Unlisted procedure, rectum</td>
</tr>
</tbody>
</table>

**ANUS**

**INCISION**

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

**EXCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>46200</td>
<td>Fissurectomy, including sphincterotomy, when performed</td>
</tr>
<tr>
<td>46221</td>
<td>Hemorrhoidectomy, internal, by rubber band ligation(s)</td>
</tr>
<tr>
<td>46945</td>
<td>Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group, without imaging guidance</td>
</tr>
<tr>
<td>46946</td>
<td>2 or more hemorrhoid columns/group, without imaging guidance</td>
</tr>
<tr>
<td>46948</td>
<td>Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups including ultrasound guidance, with mucopexy, when performed</td>
</tr>
<tr>
<td>46220</td>
<td>Excision of single external papilla or tag, anus</td>
</tr>
<tr>
<td>46230</td>
<td>Excision of multiple external papillae or tags, anus</td>
</tr>
<tr>
<td>46320</td>
<td>Excision of thrombosed hemorrhoid, external</td>
</tr>
<tr>
<td>46250</td>
<td>Hemorrhoidectomy, external, 2 or more columns/groups</td>
</tr>
<tr>
<td>46255</td>
<td>Hemorrhoidectomy, internal and external, simple column/group; with fissurectomy</td>
</tr>
<tr>
<td>46257</td>
<td>with fistulectomy, including fissurectomy, when performed</td>
</tr>
<tr>
<td>46260</td>
<td>Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fissurectomy</td>
</tr>
<tr>
<td>46261</td>
<td>with fistulectomy, including fissurectomy, when performed</td>
</tr>
<tr>
<td>46270</td>
<td>Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous intersphincteric</td>
</tr>
<tr>
<td>46275</td>
<td>transspihincteric, suprasphtincteric, extrasphincteric or multiple, including placement of seton, when performed (Do not report 46280 in conjunction with 46020)</td>
</tr>
<tr>
<td>46280</td>
<td>Closure of anal fistula with rectal advancement flap</td>
</tr>
</tbody>
</table>

**INTRODUCTION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>46500</td>
<td>Injection of sclerosing solution, hemorrhoids</td>
</tr>
<tr>
<td>46505</td>
<td>Chemodenervation of internal anal sphincter</td>
</tr>
</tbody>
</table>
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
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, chemo surgery)
46930  Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radio frequency)
46940  Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); initial
46942    subsequent

SUTURE

46947  Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling

OTHER PROCEDURES

46999  Unlisted procedure, anus

LIVER

INCISION

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

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

**LIVER TRANSPLANTATION**

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

**REPAIR**

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

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

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

**OTHER PROCEDURES**

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

**BILIARY TRACT**

**INCISION**

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

47490 Cholecystotomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation

47531 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access

47532 New access (eg, percutaneous transhepatic cholangiogram)
   (Do not report 47531, 47532 in conjunction with 47490, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540, 47541 for procedures performed though the same percutaneous access)
   (For intraoperative cholangiography, see 74300, 74301)

47533 Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external

47534 Internal-external

47535 Conversion of external biliary drainage catheter to internal-external biliary catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation

47536 Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated 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, 47537, 47541)
   (Do not report 47542 in conjunction with 43262, 43277, 47538, 47539, 47540, 47555, 47556)
(Do not report 47542 in conjunction with 47544 if a balloon is used for removal of calculi, debris, and/or sludge rather than for dilation)

(For percutaneous balloon dilation of multiple ducts during the same session, report an additional dilation once with 47542 and modifier 59, regardless of the number of additional ducts dilated)

(For endoscopic balloon dilation, see 43277, 47555, 47556)

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

(List separately in addition to code for primary procedure)

(Use 47543 in conjunction with 47531, 47532, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540)

(Report 47543 once per session)

(For endoscopic brushings, see 43260, 47552)

(For endoscopic biopsy, see 43261, 47553)

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

ENDOSCOPY

Surgical endoscopy always includes diagnostic endoscopy.

47550 Biliary endoscopy, intraoperative (choledochoscopy)

(List separately in addition to primary procedure)

47552 Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with collection of specimen(s) by brushing and/or washing, when performed (separate procedure)

47553 with biopsy, single or multiple

47554 with removal of calculus/calculi

47555 with dilation of biliary duct stricture(s) without stent

47556 with dilation of biliary duct stricture(s) with stent

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy

47562 Laparoscopy; surgical; cholecystectomy

47563 cholecystectomy with cholangiography

47564 cholecystectomy with exploration of common duct

47570 cholecystoenterostomy

47579 Unlisted laparoscopy procedure, biliary tract

EXCISION

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

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

OTHER PROCEDURES
47999 Unlisted procedure, biliary tract

PANCREAS

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

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

INTRODUCTION

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

REPAIR

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

PANCREAS TRANSPLANTATION

48554 Transplantation of pancreatic allograft
48556 Removal of transplanted pancreatic allograft

OTHER PROCEDURES

48999 Unlisted procedure, pancreas

ABDOMEN, PERITONEUM, AND OMENTUM

INCISION

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

EXCISION, DESTRUCTION

49180 Biopsy, abdominal or retroperitoneal mass, percutaneous needle
49185 Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation, when performed
(For treatment of multiple lesions in a single day requiring separate access, use modifier 59 for each additional treated lesion)
(For treatment of multiple interconnected lesions treated through a single access, report 49185 once)
49203 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less
49204 largest tumor 5.1-10.0 cm diameter
49205 largest tumor greater than 10.0 cm diameter
(Do not report 49203-49205 in conjunction with 38770, 38780, 49000, 49010, 49215, 50010, 50205, 50225, 50236, 50250, 50290, 58900-58960)
49215 Excision of presacral or sacrococcygeal tumor
(Do not report modifier 63 in conjunction with 49215)
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 Umbillectomy, omphalectomy, excision of umbilicus (separate procedure)
49255 Omentectomy, epiploectomy, resection of omentum (separate procedure)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

49320 Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
49321 Laparoscopy, surgical; with biopsy (single or multiple)
49322 with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)
49323 with drainage of lymphocele to peritoneal cavity
49324 with insertion of tunneled intraperitoneal catheter
49325 with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed
49326  with omentopexy (omental tacking procedure)
        (List separately in addition to primary procedure)
        (Use 49326 in conjunction with 49324, 49325)

49327  with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial
        markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including
        imaging guidance, if performed, single or multiple
        (List separately in addition to primary procedure)
        (Use 49327 in conjunction with laparoscopic abdominal, pelvic, or retroperitoneal
        procedure[s] performed concurrently)

49329  Unlisted laparoscopy procedure, abdomen, peritoneum and omentum

INTRODUCTION, REVISION AND/OR REMOVAL

49400  Injection of air or contrast into peritoneal cavity (separate procedure)
49402  Removal of peritoneal foreign body from peritoneal cavity
49405  Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma,
        lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous
49406        peritoneal or retroperitoneal, percutaneous
49407        peritoneal or retroperitoneal, transvaginal or transrectal
49411  Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers,
        dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or
        retroperitoneum, single or multiple
49412  Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers,
        dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image
        guidance, if performed, single or multiple
        (List separately in addition to primary procedure)
        (Use 49412 in conjunction with open abdominal, pelvic, or retroperitoneal procedure[s]
        performed concurrently)
49418  Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy
        instillation, management of ascites), complete procedure, including imaging guidance,
        catheter placement, contrast injection when performed, and radiological supervision and
        interpretation, percutaneous
49419  Insertion of tunneled intraperitoneal catheter, with subcutaneous port (ie, totally implantable)
49421  Insertion of tunneled intraperitoneal catheter for dialysis, open
49422  Removal of tunneled intraperitoneal catheter
49423  Exchange of previously placed abscess or cyst drainage catheter under radiological
        guidance (separate procedure)
49424  Contrast injection for assessment of abscess or cyst via previously placed drainage catheter
        or tube (separate procedure)
49425  Insertion of peritoneal-venous shunt
49426  Revision of peritoneal-venous shunt
49427  Injection procedure (eg, contrast media) for evaluation of previously placed peritoneal-
        venous shunt
49428  Ligation of peritoneal-venous shunt
49429  Removal of peritoneal-venous shunt
49435 Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site
   (List separately in addition to primary procedure)
   (Use 49435 in conjunction with 49324, 49421)
49436 Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter

INITIAL PLACEMENT

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

49440 Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
   (For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, use 49440 in conjunction with 49446)
49441 Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
49442 Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

CONVERSION

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

REPLACEMENT

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

49450 Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
49451 Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
49452 Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

MECHANICAL REMOVAL OF OBSTRUCTIVE MATERIAL

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

OTHER

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

REPAIR

HERNIOPLASTY, HERNIORRHAPHY, HERNIOTOMY

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

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

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

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

49491  Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks post-conception age, with or without hydrocelectomy; reducible
49492  incarcerated or strangulated
49495  Repair initial inguinal hernia, full term infant younger than 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; reducible
49496  incarcerated or strangulated
49500  Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible
49501  incarcerated or strangulated
49505  Repair initial inguinal hernia, age 5 years or over; reducible
49507  incarcerated or strangulated
49520  Repair recurrent inguinal hernia, any age; reducible
49521  incarcerated or strangulated
49525  Repair inguinal hernia, sliding, any age
49540  Repair lumbar hernia
49550  Repair initial femoral hernia, any age; reducible
49553  incarcerated or strangulated
49555  Repair recurrent femoral hernia; reducible
49557  incarcerated or strangulated
49560  Repair initial incisional or ventral hernia; reducible
49561    incarcerated or strangulated
49565  Repair recurrent incisional or ventral hernia; reducible
49566    incarcerated or strangulated
49568  Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh
for closure of debridement for necrotizing soft tissue infection
(List separately in addition to code for the incisional or ventral hernia repair)
(Use 49568 in conjunction with 11004-11006, 49560-49566)
49570  Repair epigastric hernia (eg. preperitoneal fat); reducible (separate procedure);
49572    incarcerated or strangulated
49580  Repair umbilical hernia, younger than age 5 years; reducible
49582    incarcerated or strangulated
49585  Repair umbilical hernia, age 5 years or over; reducible
49587    incarcerated or strangulated
49590  Repair spigelian hernia
49600  Repair of small omphalocele, with primary closure
49605  Repair of large omphalocele or gastroschisis; with or without prosthesis
49606    with removal of prosthesis, final reduction and closure, in operating room
49610  Repair of omphalocele (Gross type operation); first stage
49611    second stage

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

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

**SUTURE**

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

**OTHER PROCEDURES**

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

**URINARY SYSTEM**

**KIDNEY**

**INCISION**

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

**EXCISION**

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

**RENEAL TRANSPLANTATION**

Version 2020
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

RENAI 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;
   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
   existing access
(Do not report 50430, 50431 in conjunction with 50432, 50433, 50434, 50435, 50693, 50694, 50695, 74425 for the same renal collecting system and/or associated ureter)

50432 Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation

50433 Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access
(Do not report 50433 in conjunction with 50430, 50431, 50432, 50693, 50694, 50695, 74425 for the same renal collecting system and/or associated ureter)

50434 Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via existing nephrostomy tract
(Do not report 50434 in conjunction with 50430, 50431, 50435, 50684, 50693, 74425 for the same renal collecting system and/or associated ureter)

50435 Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
(Do not report 50435 in conjunction with 50430, 50431, 50434, 50693, 74425 for the same renal collecting system and/or associated ureter)

REPAIR

50400 Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple
50405 complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calycoplasty)

50500 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
50694   new access, without separate nephrostomy catheter
50695   new access, with separate nephrostomy catheter
(Do not report 50693, 50694, 50695 in conjunction with 50430, 50431, 50432, 50433, 50434, 50435, 50684, 74425 for the same renal collecting system and/or associated ureter)

**REPAIR**

50700  Ureteroplasty, plastic operation on ureter (eg, stricture)
50705  Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
50706  Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
(Do not report 50706 in conjunction with 50553, 50572, 50953, 50972, 52341, 52344, 52345, 74485)
50715  Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis
50722  Ureterolysis for ovarian vein syndrome
50725  Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava
50727  Revision of urinary-cutaneous anastomosis (any type urostomy); with repair of fascial defect and hernia
50740  Ureteropyelostomy, anastomosis of ureter and renal pelvis
50750  Ureterocalycostomy, anastomosis of ureter to renal calyx
50760  Ureteroureterostomy
50770  Transureteroureterostomy, anastomosis of ureter to contralateral ureter
50780  Ureteroneocystostomy; anastomosis of single ureter to bladder
50782   anastomosis of duplicated ureter to bladder
50783  with extensive ureteral tailoring
50785  with vesico-psoas hitch or bladder flap
(Codes 50780-50785 include minor procedures to prevent vesicoureteral reflux)
50800  Ureterointerostomy, direct anastomosis of ureter to intestine
50810  Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis
50815  Ureterocolon conduit, including intestine anastomosis
50820  Ureteroileal conduit (ileal bladder), including intestine anastomosis (Bricker operation)
50825  Continent diversion, including intestine anastomosis using any segment of small and/or large bowel (Kock pouch or Camey enterocystoplasty)
50830  Urinary undiversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureterointerostomy 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 ureterovesical 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);
   with urethral pressure profile studies (ie, urethral closure pressure profile), any technique
51727 with voiding pressure studies (ie, bladder voiding pressure), any technique
51728 with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique
51736 Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)
51741 Complex uroflowmetry (eg, calibrated electronic equipment)
51784 Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique
51785 Needle electromyography studies (EMG) of anal or urethral sphincter, any technique
51792 Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)
51797 Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to primary procedure) (Use 51797 in conjunction with 51728, 51729)
51798 Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging

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

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

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

**ENDOSCOPY - CYSTOSCOPY, URETHROSCOPY, CYSTOURETHROSCOPY**

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

52000  Cystourethroscopy (separate procedure)
52001  Cystourethroscopy with irrigation and evacuation of multiple obstructing clots
      (Do not report 52001 in addition to 52000)
52005  Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
52007    with brush biopsy of ureter and/or renal pelvis
52010  Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service

**TRANSURETHRAL SURGERY**

**URETHRA AND BLADDER**
52204  Cystourethroscopy, with biopsy(s)
52214  Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
52224  Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s), with or without biopsy
52234  Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)
52235  MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52240  LARGE bladder tumor(s)
52250  Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration
52260  Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
52265  local anesthesia
52270  Cystourethroscopy, with internal urethrotomy; female
52271  male
52275  Cystourethroscopy, with direct vision internal urethrotomy
52280  Cystourethroscopy, with resection of external sphincter (sphincterotomy)
52281  Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
52282  Cystourethroscopy, with insertion of permanent urethral stent
52283  Cystourethroscopy, with steroid injection into stricture
52285  Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone
52287  Cystourethroscopy, with injection(s) for chemodenervation of the bladder
52290  Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral
52300  with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral
52301  with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral
52305  with incision or resection of orifice of bladder diverticulum, single or multiple
52310  Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple
52315  complicated
52317  Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)
52318  complicated or large (over 2.5 cm)

URETER AND PELVIS

Therapeutic cystourethroscopy always includes diagnostic cystourethroscopy. To report a diagnostic cystourethroscopy, use 52000. Therapeutic cystourethroscopy with ureteroscopy and/or pyeloscopy always includes diagnostic cystourethroscopy with ureteroscopy and/or pyeloscopy. To report a diagnostic cystourethroscopy with ureteroscopy and/or pyeloscopy, use 52351.

Do not report 52000 in conjunction with 52320-52343.
Do not report 52351 in conjunction with 52344-52346, 52352-52355.

The insertion and removal of a temporary ureteral catheter (52005) during diagnostic or therapeutic cystourethrosopic with ureteroscopy and/or pyeloscopy is included in 52320-52355 and should not be reported separately.

<table>
<thead>
<tr>
<th>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>
<tr>
<td></td>
<td>(Do not report 52351 in conjunction with 52341-52346, 52352-52355)</td>
</tr>
<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 (eg, 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>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</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) of postoperative bladder neck contracture</td>
</tr>
<tr>
<td>52640</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>52647</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>52648</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) (Do not report 52649 in conjunction with 52000, 52276, 52281, 52601, 52647, 52648, 53020, 55250)</td>
</tr>
<tr>
<td>52649</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>
<tr>
<td></td>
<td>(Do not report modifier -63 in conjunction with 53025)</td>
</tr>
<tr>
<td>53040</td>
<td>Drainage of deep periurethral abscess</td>
</tr>
<tr>
<td>53060</td>
<td>Drainage of Skene’s gland abscess or cyst</td>
</tr>
<tr>
<td>53080</td>
<td>Drainage of perineal urinary extravasation; uncomplicated (separate procedure)</td>
</tr>
<tr>
<td>53085</td>
<td>complicated</td>
</tr>
</tbody>
</table>

**EXCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53200</td>
<td>Biopsy of urethra</td>
</tr>
<tr>
<td>53210</td>
<td>Urethrectomy, total, including cystostomy; female</td>
</tr>
<tr>
<td>53215</td>
<td>male</td>
</tr>
<tr>
<td>53220</td>
<td>Excision or fulguration of carcinoma of urethra</td>
</tr>
<tr>
<td>53230</td>
<td>Excision of urethral diverticulum (separate procedure); female</td>
</tr>
<tr>
<td>53235</td>
<td>male</td>
</tr>
<tr>
<td>53240</td>
<td>Marsupialization of urethral diverticulum, male or female</td>
</tr>
<tr>
<td>53250</td>
<td>Excision of bulbourethral gland (Cowper's gland)</td>
</tr>
<tr>
<td>53260</td>
<td>Excision or fulguration; urethral polyp(s), distal urethra</td>
</tr>
<tr>
<td>53265</td>
<td>urethral caruncle</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>53270</td>
<td>Skene's glands</td>
</tr>
<tr>
<td>53275</td>
<td>urethral prolapse</td>
</tr>
<tr>
<td></td>
<td><strong>REPAIR</strong></td>
</tr>
<tr>
<td>53400</td>
<td>Urethroplasty; first stage, for fistula, diverticulum, or stricture, (eg, Johannsen type)</td>
</tr>
<tr>
<td>53405</td>
<td>second stage (formation of urethra), including urinary diversion</td>
</tr>
<tr>
<td>53410</td>
<td>Urethroplasty, one-stage reconstruction of male anterior urethra</td>
</tr>
<tr>
<td>53415</td>
<td>Urethroplasty, transpubic or perineal, one stage, for reconstruction or repair of prostatic or membranous urethra</td>
</tr>
<tr>
<td>53420</td>
<td>Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage</td>
</tr>
<tr>
<td>53425</td>
<td>second stage</td>
</tr>
<tr>
<td>53430</td>
<td>Urethroplasty, reconstruction of female urethra</td>
</tr>
<tr>
<td>53431</td>
<td>Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg, Tenago, Leadbetter procedure)</td>
</tr>
<tr>
<td>53440</td>
<td>Sling operation for correction of male urinary incontinence, (eg, fascia or synthetic)</td>
</tr>
<tr>
<td>53442</td>
<td>Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)</td>
</tr>
<tr>
<td>53444</td>
<td>Insertion of tandem cuff (dual cuff)</td>
</tr>
<tr>
<td>53445</td>
<td>Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff</td>
</tr>
<tr>
<td>53446</td>
<td>Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff</td>
</tr>
<tr>
<td>53447</td>
<td>Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir and cuff at the same operative session</td>
</tr>
<tr>
<td>53448</td>
<td>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)</td>
</tr>
<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>Urethrorrhaphy, 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 urethrostomy or urethrocathetaneous fistula, male (separate procedure)</td>
</tr>
<tr>
<td></td>
<td><strong>MANIPULATION</strong></td>
</tr>
<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>
</tbody>
</table>

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53605  Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia

53620  Dilation of urethral stricture by passage of filiform and follower, male; initial

53621  subsequent

53660  Dilation of female urethra including suppository and/or instillation; initial

53661  subsequent

53665  Dilation of female urethra, general or conduction (spinal) anesthesia

OTHER PROCEDURES

53850  Transurethral destruction of prostate tissue; by microwave thermotherapy

53852     by radiofrequency thermotherapy

53855  Insertion of a temporary prostatic urethral stent, including urethral measurement

53860  Transurethral radiofrequency micro-modeling of the female bladder neck and proximal urethra for stress urinary incontinence

53899  Unlisted procedure, urinary system

MALE GENITAL SYSTEM

PENIS

INCISION

54000  Slitting of prepuce, dorsal or lateral (separate procedure); newborn

(Do not report modifier –63 in conjunction with 54000)

54001     except newborn

54015  Incision and drainage of penis, deep

DESTRUCTION

54050  Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical

54055     electrodessication

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 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; 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, prepuicial 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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54336</td>
<td>One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap</td>
</tr>
<tr>
<td>54340</td>
<td>Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple</td>
</tr>
<tr>
<td>54344</td>
<td>requiring mobilization of skin flaps and urethroplasty with flap or patch graft</td>
</tr>
<tr>
<td>54348</td>
<td>requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)</td>
</tr>
<tr>
<td>54352</td>
<td>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</td>
</tr>
<tr>
<td>54360</td>
<td>Plastic operation on penis to correct angulation</td>
</tr>
<tr>
<td>54380</td>
<td>Plastic operation on penis for epispadias distal to external sphincter;</td>
</tr>
<tr>
<td>54385</td>
<td>with incontinence</td>
</tr>
<tr>
<td>54390</td>
<td>with extrophy of bladder</td>
</tr>
<tr>
<td>54400</td>
<td>Insertion of penile prosthesis; non-inflatable (semi-rigid)</td>
</tr>
<tr>
<td>54401</td>
<td>inflatable (self-contained)</td>
</tr>
<tr>
<td>54405</td>
<td>Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir</td>
</tr>
<tr>
<td>54406</td>
<td>Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis</td>
</tr>
<tr>
<td>54408</td>
<td>Repair of component(s) of a multi-component, inflatable penile prosthesis</td>
</tr>
<tr>
<td>54410</td>
<td>Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session</td>
</tr>
<tr>
<td>54411</td>
<td>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)</td>
</tr>
<tr>
<td>54415</td>
<td>Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis</td>
</tr>
<tr>
<td>54416</td>
<td>Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session</td>
</tr>
<tr>
<td>54417</td>
<td>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)</td>
</tr>
<tr>
<td>54420</td>
<td>Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral</td>
</tr>
<tr>
<td>54430</td>
<td>Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilateral</td>
</tr>
<tr>
<td>54435</td>
<td>Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism</td>
</tr>
<tr>
<td>54437</td>
<td>Repair of traumatic corporeal tear(s)</td>
</tr>
<tr>
<td>54438</td>
<td>Replantation, penis, complete amputation including urethral repair</td>
</tr>
<tr>
<td>54440</td>
<td>Plastic operation of penis for injury</td>
</tr>
</tbody>
</table>

**MANIPULATION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54450</td>
<td>Foreskin manipulation including lysis of preputial adhesions and stretching</td>
</tr>
</tbody>
</table>
TESTIS

EXCISION

54500 Biopsy of testis, needle (separate procedure)
54505 Biopsy of testis, incisional (separate procedure)
   (For bilateral procedure, use modifier -50)
54512 Excision of extraparenchymal lesion of testis
54520 Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or
   inguinal approach
   (For bilateral procedure, use modifier -50)
54522 Orchiectomy, partial
54530 Orchiectomy, radical, for tumor; inguinal approach
54535 with abdominal exploration

EXPLORATION

(For 54550, 54560 for bilateral procedure, use modifier -50)
54550 Exploration for undescended testis (inguinal or scrotal area)
54560 Exploration for undescended testis with abdominal exploration

REPAIR

54600 Reduction of torsion of testis, surgical, with or without fixation of contralateral testis
54620 Fixation of contralateral testis (separate procedure)
54640 Orchiopexy, inguinal or scrotal approach
   (For bilateral procedure, use modifier 50)
54650 Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)
54660 Insertion of testicular prosthesis (separate procedure)
   (For bilateral procedure, use modifier 50)
54670 Suture or repair of testicular injury
54680 Transplantation of testis(es) to thigh (because of scrotal destruction)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

54690 Laparoscopy, surgical; orchiectomy
54692 orchiopexy for intra-abdominal testis
54699 Unlisted laparoscopy procedure, testis

EPIDIDYMIS

INCISION

54700 Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)
54800  Biopsy of epididymis, needle
54830  Excision of local lesion of epididymis
54840  Excision of spermatocele, with or without epididymectomy
54860  Epididymectomy; unilateral
54861  bilateral

**EXPLORATION**

54865  Exploration of epididymis, with or without biopsy

**TUNICA VAGINALIS**

**INCISION**

55000  Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication

**EXCISION**

55040  Excision of hydrocele; unilateral
55041  bilateral

**REPAIR**

55060  Repair of tunica vaginalis hydrocele (Bottle type)

**SCROTUM**

**INCISION**

55100  Drainage of scrotal wall abscess
      (See also 54700)
55110  Scrotal exploration
55120  Removal of foreign body in scrotum

**EXCISION**

55150  Resection of scrotum

**REPAIR**

55175  Scrotoplasty; simple
55180  complicated

**VAS DEFERENS**

**INCISION**

55200  Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)

**EXCISION**
55250  Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)

SPERMATIC CORD

EXCISION

55500  Excision of hydrocele of spermatic cord, unilateral (separate procedure)
55520  Excision of lesion of spermatic cord (separate procedure)
55530  Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)
      55535    abdominal approach
55540    with hernia repair

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

55550  Laparoscopy, surgical, with ligation of spermatic veins for varicocele
55559  Unlisted laparoscopy procedure, spermatic cord

SEMINAL VESICLES

INCISION

55600  Vesiculotomy;
      (For bilateral procedure, use modifier 50)
55605    complicated

EXCISION

55650  Vesiculectomy, any approach
      (For bilateral procedure, use modifier 50)
55680  Excision of Mullerian duct cyst

PROSTATE

INCISION

55700  Biopsy, prostate; needle or punch, single or multiple, any approach
55705    incisional, any approach
55720  Prostatotomy, external drainage of prostatic abscess, any approach; simple
55725    complicated

EXCISION

55801  Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)
55810  Prostatectomy, perineal radical;
55812 with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55815 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
   (If 55815 is carried out on separate days, use 38770 and 55810)
55821 Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, one or two stages
55831 retropubic, subtotal
55840 Prostatectomy, retropubic radical, with or without nerve sparing;
55842 with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55845 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
   (If 55845 is carried out on separate days, use 38770 and 55840)
55860 Exposure of prostate, any approach, for insertion of radioactive substance;
55862 with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55865 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

55866 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed

**OTHER PROCEDURES**

55873 Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)
55875 Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
55876 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostrate (via needle, any approach, single or multiple
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
19318: Reduction mammaplasty (unilateral)
19324: Mammaplasty, augmentation; without prosthetic implant
19325: with prosthetic implant

For male-to-female gender reassignment, augmentation mammaplasty may be considered medically necessary for individuals with a diagnosis of gender dysphoria when that individual 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: Vermilionectomy (lip shave), with mucosal advancement
67900: Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

**FEMALE GENITAL SYSTEM**

**VULVA, PERINEUM AND INTROITUS**
The following definitions apply to the vulvectomy codes (56620-56640):

**Simple**: The removal of skin and superficial subcutaneous tissue.

**Radical**: The removal of skin and deep subcutaneous tissue.

**Partial**: Removal of less than 80% of the vulvar area.

**Complete**: The removal of greater than 80% of the vulvar area.

**INCISION**

56405 Incision and drainage of vulva or perineal abscess
56420 Incision and drainage of Bartholin's gland abscess
56440 Marsupialization of Bartholin's gland cyst
56441 Lysis of labial adhesions
56442 Hymenotomy, simple incision

**DESTRUCTION**

56501 Destruction of lesion(s), vulva; simple, (laser surgery, electrosurgery, cryosurgery, chemosurgery)
56515 extensive, (laser surgery, electrosurgery, cryosurgery, chemosurgery)

**EXCISION**

56605 Biopsy of vulva or perineum. (separate procedure); one lesion
56606 each separate additional lesion
   (List separately in addition to primary procedure)
   (Use 56606 in conjunction with 56605)
56620 Vulvectomy simple; partial
56625 complete
56630 Vulvectomy, radical, partial;
56631 with unilateral inguino-femoral lymphadenectomy
56632 with bilateral inguino-femoral lymphadenectomy
56633 Vulvectomy, radical, complete;
56634 with unilateral inguino-femoral lymphadenectomy
56637 with bilateral inguino-femoral lymphadenectomy
56640 Vulvectomy, radical, complete, with inguino-femoral, 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; with enterocele repair
57265 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)
57267 Repair of enterocele, vaginal approach (separate procedure)
57268 Repair of enterocele, abdominal approach (separate procedure)
57269 Combined anteroposterior colporrhaphy; including cystourethroscopy, when performed; with enterocele repair
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 bulbocavernousus transplant
57320 Closure of vesicovaginal fistula; vaginal approach
57330 transvesical and vaginal approach
57335 Vaginoplasty for intersex state

MANIPULATION

57400 Dilation of vagina under anesthesia (other than local)
57410 Pelvic examination under anesthesia (other than local)
57415 Removal of impacted vaginal foreign body (separate procedure) under anesthesia (other than local)
(For removal without anesthesia of an impacted vaginal foreign body, use the appropriate Evaluation and Management code)

**ENDOSCOPY**

57420  Colposcopy of the entire vagina, with cervix if present;
57421   with biopsy(s) of vagina/cervix
57423  Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach
   (Do not report 57423 in conjunction with 49320, 51840, 51841, 51990, 57240, 57260, 58152, 58267)
57425  Laparoscopy, surgical, colpopexy (suspension of vaginal apex)
57426  Revision (including removal) of prosthetic vaginal graft, laparoscopic approach

**CERVIX UTERI**

**ENDOSCOPY**

57452  Colposcopy of the cervix including upper/adjacent vagina;
   (Do not report 57452 in addition to 57454-57461)
57454   with biopsy(s) of the cervix and endocervical curettage
57455   with biopsy(s) of the cervix
57456   with endocervical curettage
57460  with loop electrode biopsy(s) of the cervix
57461  with loop electrode conization of the cervix
   (Do not report 57456 in addition to 57461)

**EXCISION**

57500  Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration
   (separate procedure)
57505  Endocervical curettage (not done as part of a dilation and curettage)
57510  Cautery of cervix; electro or thermal
57511   cryocautery, initial or repeat
57513  laser ablation
57520  Conization of cervix, with or without fulguration, with or without dilation and curettage, with or
   without repair; cold knife or laser
   (See also 58120)
57522   loop electrode excision
57530  Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
57531  Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph
   node sampling biopsy, with or without removal of tube(s), with or without removal of ovary(s)
57540  Excision of cervical stump, abdominal approach;
57545   with pelvic floor repair
57550  Excision of cervical stump, vaginal approach;
57555   with anterior and/or posterior repair
57556  with repair of enterocele
57558  Dilation and curettage of cervical stump
REPAIR
57700  Cerclage of uterine cervix, nonobstetrical
57720  Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach

MANIPULATION
57800  Dilation of cervical canal, instrumental (separate procedure)

CORPUS UTERI

EXCISION
58100  Endometrial sampling (biopsy), with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
58110  Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to primary procedure) (Use 58110 in conjunction with 57420, 57421, 57452-57461)
58120  Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
58140  Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 grams or less and/or removal of surface myomas; abdominal approach
58145  vaginal approach
58146  Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach (Do not report 58146 in addition to 58140-58145, 58150-58240)

HYSTERECTOMY PROCEDURES
(For codes 58150-58294, See Rule 14, Receipt of Hysterectomy Information)
58150  Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58152  with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)
58180  Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58200  Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)
58210  Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)
58240  Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
58260  Vaginal hysterectomy, for uterus 250 grams or less;
58262  with removal of tube(s), and/or ovary(s)
58263  with removal of tube(s), and/or ovary(s), with repair of enterocele
(Do not report 58263 in addition to 57283)

58267  with colpo-urethrocystopexy (Marshall-Marchetti-Krantz Type, Pereyra type, with or without endoscopic control)
58270  with repair of enterocele
58275  Vaginal hysterectomy, with total or partial vaginectomy;
58280  with repair of enterocele
58285  Vaginal hysterectomy, radical (Schauta type operation)
58290  Vaginal hysterectomy, for uterus greater than 250 grams;
58291  with removal of tube(s) and/or ovary(s)
58292  with removal of tube(s) and/or ovary(s), with repair of enterocele
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
58955 Bilateral salpingo-oophorectomy with 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)
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)

59877 Unlisted fetal invasive procedure, including ultrasound guidance, when performed

59898 Unlisted laparoscopy procedure, maternity care and delivery
59899 Unlisted procedure, maternity care and delivery

**ENDOCRINE SYSTEM**

**THYROID GLAND**

**INCISION**

60000 Incision and drainage of thyroglossal duct cyst, infected

**EXCISION**

60100 Biopsy thyroid, percutaneous core needle
60200 Excision of cyst or adenoma of thyroid, or transection of isthmus
60210 Partial thyroid lobectomy, unilateral; with or without isthmusectomy
60212 with contralateral subtotal lobectomy, including isthmusectomy
60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy
60225 with contralateral subtotal lobectomy, including isthmusectomy
60240 Thyroidectomy, total or complete
60252 Thyroidectomy, total or subtotal for malignancy; with limited neck dissection
60254 with radical neck dissection
60260 Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid
   (For bilateral procedure, use modifier -50)
60270 Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach
60271 cervical approach
60280 Excision of thyroglossal duct cyst or sinus;
   60281 recurrent

**REMOVAL**

60300 Aspiration and/or injection, thyroid cyst

**PARATHYROID, THYMUS, ADRENAL GLANDS, PANCREAS, AND CARTOID BODY**

**EXCISION**

60500 Parathyroidectomy or exploration of parathyroid(s);
60502 re-exploration
60505 with mediastinal exploration, sternal split or transthoracic approach
60512 Parathyroid autotransplantation
   (List separately in addition to primary procedure)
   (Use 60512 in conjunction with codes 60500, 60502, 60505, 60212, 60225, 60240, 60252, 60254, 60260, 60270, 60271)
60520 Thymectomy, partial or total; transcervical approach (separate procedure)
60521 sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)
60522 sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)
60540  Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure);
60545  with excision of adjacent retroperitoneal tumor
   (For bilateral procedure, use modifier -50)
   (For laparoscopic approach, use 60650)
60600  Excision of carotid body tumor; without excision of carotid artery
60605  with excision of carotid artery

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

60650  Laparoscopy, surgical; with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal
60659  Unlisted laparoscopy procedure, endocrine system

OTHER PROCEDURES

60699  Unlisted procedure, endocrine system

NERVOUS SYSTEM

SKULL, MENINGES, AND BRAIN

INJECTION, DRAINAGE OR ASPIRATION

61000  Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initial
61001  subsequent taps
61020  Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection
61026  with injection of medicament or other substance for diagnosis or treatment
61050  Cisternal or lateral cervical (Cl-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 TREPINE

(For codes 61107, 61210 for intracranial neuroendoscopic ventricular catheter placement, use 62160)

61105  Twist drill hole for subdural or ventricular puncture;
61107  Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for implanting ventricular catheter, pressure recording device, or other intracerebral monitoring device
61108  for evacuation and/or drainage of subdural hematoma
61120  Burr hole(s) for ventricular puncture (including injection of gas, contrast media, dye or radioactive material);
61140  Burr hole(s) or trephine; with biopsy of brain or intracranial lesion
61150  with drainage of brain abscess or cyst
61151  with subsequent tapping (aspiration) of intracranial abscess or cyst
61154 Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural
   (For bilateral procedure, use modifier -50)
61156 Burr hole(s); with aspiration of hematoma or cyst, intracerebral
61210 for implanting ventricular catheter, reservoir, EEG electrode(s), pressure recording
device, or other cerebral monitoring device (separate procedure)
61215 Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to
ventricular catheter
61250 Burr hole(s) or trephine, supratentorial, exploratory, not followed by other surgery
   (For bilateral procedure, use modifier -50)
61253 Burr hole(s) or trephine, infratentorial, unilateral or bilateral
   (If burr hole(s) or trephine followed by craniotomy at same operative session use 61304-
   61321; do not use 61250 or 61253)

CRANIECTOMY OR CRANIOTOMY

61304 Craniectomy or craniotomy, exploratory; supratentorial
61305 infratentorial (posterior fossa)
61312 Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or
   subdural
61313 intracerebral
61314 Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural
61315 intracerebellar
61316 Incision and subcutaneous placement of cranial bone graft
   (List separately in addition to primary procedure)
   (Use 61316 in conjunction with codes 61304, 61312, 61313, 61322, 61323, 61340, 61570,
   61571, 61680-61705)
61320 Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial
61321 infratentorial
61322 Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of
   intracranial hypertension, without evacuation of associated intraparenchymal hematoma;
   without lobectomy
61323 with lobectomy
   (Do not report 61313 in addition to 61322, 61323)
61330 Decompression of orbit only, transcranial approach
   (For bilateral procedure, use modifier -50)
61333 Exploration of orbit (transcranial approach) with removal of lesion
61340 Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome)
   (For bilateral procedure, use modifier -50)
61343 Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal
cord, with or without dural graft (eg, Arnold-Chiari malformation)
61345 Other cranial decompression, posterior fossa
61450 Craniectomy, subtemporal, for section, compression, or decompression of sensory root of
   gasserian ganglion
61458 Craniectomy, suboccipital; for exploration or decompression of cranial nerves
61460 for section of one or more cranial nerves
61500  Craniectomy; with excision of tumor or other bone lesion of skull
61501    for osteomyelitis
61510  Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma
61512    for excision of meningioma, supratentorial
61514    for excision of brain abscess, supratentorial
61516    for excision or fenestration of cyst, supratentorial
61517  Implantation of brain intracavitary chemotherapy agent
          (List separately in addition to primary procedure)
          (Use 61517 only in conjunction with codes 61510 or 61518)
          (Do not report 61517 for brachytherapy insertion. For intracavitary insertion of radioelement sources or ribbons, see 77781-77784)
61518  Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull
61519    meningioma
61520    cerebellopontine angle tumor
61521    midline tumor at base of skull
61522  Craniectomy, infratentorial or posterior fossa; for excision of brain abscess
61524    for excision or fenestration of cyst
61526  Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;
61530    combined with middle/posterior fossa craniotomy/craniectomy
61531  Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring
61533  Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring
61534    for excision of epileptogenic focus without electrocorticography during surgery
61535    for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)
61536    for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)
61537    for lobectomy, temporal lobe, without electrocorticography during surgery
61538    for lobectomy, temporal lobe, with electrocorticography during surgery
61539    for lobectomy, other than temporal lobe, partial or total with electrocorticography during surgery
61540    for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery
61541    for transection of corpus callosum
61543    for partial or subtotal (functional) hemispherectomy
61544    for excision or coagulation of choroid plexus
61545    for excision of craniopharyngioma
61546  Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach
61548  Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic
61550  Craniectomy for craniosynostosis; single cranial suture
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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>61581</td>
<td>extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy</td>
</tr>
<tr>
<td>61582</td>
<td>extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa</td>
</tr>
<tr>
<td>61583</td>
<td>intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa</td>
</tr>
<tr>
<td>61584</td>
<td>Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); without orbital exenteration</td>
</tr>
<tr>
<td>61585</td>
<td>with orbital exenteration</td>
</tr>
<tr>
<td>61586</td>
<td>Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft</td>
</tr>
<tr>
<td>61587</td>
<td>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</td>
</tr>
<tr>
<td>61588</td>
<td>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</td>
</tr>
<tr>
<td>61589</td>
<td>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</td>
</tr>
<tr>
<td>61590</td>
<td>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</td>
</tr>
<tr>
<td>61591</td>
<td>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</td>
</tr>
<tr>
<td>61592</td>
<td>Transcondylar (far lateral) approach to posterior cranial fossa, jugular foramen or midline skull base including occipital condylectomy, mastoidectomy, resection of CI-C3 vertebral body(s), decompression of vertebral artery, with or without mobilization</td>
</tr>
<tr>
<td>61593</td>
<td>Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus</td>
</tr>
</tbody>
</table>

**DEFINITIVE PROCEDURES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>61600</td>
<td>Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; extradural</td>
</tr>
<tr>
<td>61601</td>
<td>intradural, including dural repair, with or without graft</td>
</tr>
<tr>
<td>61605</td>
<td>Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural</td>
</tr>
<tr>
<td>61606</td>
<td>intradural, including dural repair, with or without graft</td>
</tr>
<tr>
<td>61607</td>
<td>Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural</td>
</tr>
<tr>
<td>61608</td>
<td>intradural, including dural repair, with or without graft</td>
</tr>
</tbody>
</table>
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
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)
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)
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
each additional vessel in same vascular territory
(List separately in addition to primary procedure)
each additional vessel in different vascular territory
(List separately in addition to primary procedure)
(Use 61641 and 61642 in conjunction with 61640)
(61640, 61641, 61642 include all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, postdilatation angiography, and fluoroscopic guidance for the balloon dilatation)

61645  Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)

61650  Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory

61651  each additional vascular territory (List separately in addition to code for primary procedure)

(Do not report 61650 or 61651 in conjunction with 36221, 36222, 36223, 36224, 36225, 36226, 61640, 61641, 61642, 61645 for the same vascular territory)

(Do not report 61650 or 61651 in conjunction with 96420, 96422, 96423, 96425 for the same vascular territory)

**SURGERY FOR ANEURYSM, ARTERIOVENOUS MALFORMATION OR VASCULAR DISEASE**

Includes craniotomy when appropriate for procedure.

61680  Surgery of intracranial arteriovenous malformation; supratentorial, simple

61682  supratentorial, complex

61684  infratentorial, simple

61686  infratentorial, complex

61690  dural, simple

61692  dural, complex

61697  Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation

61698  vertebrobasilar circulation

(61697, 61698 involve aneurysms that are larger than 15 mm or with calcification of the aneurysm neck, or with incorporation of normal vessels into the aneurysm neck, or a procedure requiring temporary vessel occlusion, trapping or cardiopulmonary bypass to successfully treat the aneurysm)

61700  Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation

61702  vertebrobasilar circulation

61703  Surgery of intracranial aneurysm, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type)

61705  Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery

61708  by intracranial electrothrombosis

61710  by intra-arterial embolization, injection procedure, or balloon catheter

61711  Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical) arteries

**STEREOTAXIS**

Coverage for 61781-61783 Stereotactic Computer-Assisted Volumetric (Navigational) Procedures is allowed only under the following conditions:
Procedure to be performed as a pre-surgical assessment and/or intraoperative assessment, in preparation for, and execution of planned craniotomy (CPT codes 61304-61576), along with a diagnosis of arteriovenous malformation of brain, malignant or benign neoplasm of the brain, or intractable epilepsy.

61720  Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus

61735  subcortical structure(s) other than globus pallidus or thalamus

61750  Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion;

61751  with computed tomography and/or magnetic resonance guidance

61760  Stereotactic implantation of depth electrodes into the cerebrum for long term seizure monitoring

61770  Stereotactic localization, including burr hole(s); with insertion of catheter(s) or probe(s) for placement of radiation source

61781  Stereotactic computer-assisted (navigational) procedure; cranial, intradural

   (List separately in addition to primary procedure)

61782  cranial, extradural

   (List separately in addition to primary procedure)

61783  spinal

   (List separately in addition to primary procedure)

61790  Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); gasserian ganglion

61791  trigeminal medullary tract

**STEREOTACTIC RADIOSURGERY (CRANIAL)**

61796  Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion

   (Do not report 61796 more than once per course of treatment)

   (Do not report 61796 in conjunction with 61798)

61797  each additional cranial lesion, simple

   (List separately in addition to primary procedure)

   (Use 61797 in conjunction with 61796, 61798)

   (For each course of treatment, 61797 and 61799 may be reported no more than once per lesion. Do not report any combination of 61797 and 61799 more than 4 times for entire course of treatment regardless of number of lesions treated)

61798  1 complex cranial lesion

   (Do not report 61798 more than once per course of treatment)

   (Do not report 61798 in conjunction with 61796)

61799  each additional cranial lesion, complex

   (List separately in addition to primary procedure)

   (Use 61799 in conjunction with 61798)

   (For each course of treatment, 61797 and 61799 may be reported no more than once per lesion. Do not report any combination of 61797 and 61799 more than 4 times for entire course of treatment regardless of number of lesions treated)

61800  Application of stereotactic headframe for stereotactic radiosurgery
(List separately in addition to primary procedure)
(Use 61800 in conjunction with 61796, 61798)

NEUROSTIMULATORS (INTRACRANIAL)

Codes 61850-61888 apply to both simple and complex neurostimulators. For initial or subsequent electronic analysis and programming of neurostimulator pulse generators, see codes 95970-95975.

Microelectrode recording, when performed by the operating surgeon in association with implantation of neurostimulator electrode arrays, is an inclusive service and should not be reported separately. If another physician participates in neurophysiological mapping during a deep brain stimulator implantation procedure, this service may be reported by the other physician with codes 95961-95962.

61850 Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical
61860 Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral; cortical
61863 Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array
61864 each additional array
   (List separately in addition to primary procedure)
   (Use 61864 in conjunction with 61863)
61867 Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array
61868 each additional array
   (List separately in addition to primary procedure)
   (Use 61868 in conjunction with 61867)
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

62328  with fluoroscopic or CT guidance

62272  Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)

62329  with fluoroscopic or CT guidance

62273  Injection, epidural, of blood or clot patch
62280  Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions) with or without other therapeutic substance; subarachnoid
d epidural, cervical or thoracic
d epidural, lumbar, sacral (caudal)
62284  Injection procedure for myelography and/or computed tomography, lumbar
(62287  Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or 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
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
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
   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
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
   lumbar
63042  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
   thoracic
63046  lumbar
63047  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)

63084 Thoracic corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment

63085 thoracic, each additional segment
   (List separately in addition to primary procedure)
   (Use 63085 in conjunction with 63084)

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/DECOMPRESSI**

*Version 2020*
Physician - Procedure Codes, Section 5 - Surgery

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
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(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular
64405  greater occipital nerve
64408  vagus nerve
64415  brachial plexus
64416  brachial plexus, continuous infusion by catheter (including catheter placement)
64417  axillary nerve
64418  suprascapular nerve
64420  intercostal nerve, single level
64421  intercostal nerve, each additional level
64425  ilioinguinal, iliohypogastric nerves
64430  pudendal nerve
64435  paracervical (uterine) nerve
64445  sciatic nerve,
64446  sciatic nerve, continuous infusion by catheter, (including catheter placement)
64447  femoral nerve
64448  femoral nerve, continuous infusion by catheter, (including catheter placement)
64449  lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)
64450  other peripheral nerve or branch
64451  nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
64454  genicular nerve branches, including imaging guidance, when performed.
64455  Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)
(Do not report 64455 in conjunction with 64632)

64479 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

64480 cervical or thoracic, each additional level
   (List separately in addition to primary procedure)
   (Use 64480 in conjunction with 64479)

64483 lumbar or sacral, single level
64484 lumbar or sacral, each additional level
   (List separately in addition to primary procedure)
   (Use 64484 in conjunction with 64483)

64461 Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed) (Report Required)

64462 second and any additional injection site(s) (includes imaging guidance when performed)
   (List separately in addition to code for primary procedure) (Report required)
   (Do not report 64462 more than once per day)

64463 continuous infusion by catheter (includes imaging guidance when performed) (Report required)

64486 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

64487 by continuous infusion(s) (includes imaging guidance, when performed)

64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)

64489 by continuous infusions (includes imaging guidance, when performed)

64490 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level

64491 second level
   (List separately in addition to primary procedure)

64492 third and any additional level(s)
   (List separately in addition to primary procedure)

64493 lumbar or sacral; single level
64494 second level
   (List separately in addition to primary procedure)

64495 third and any additional level(s)
   (List separately in addition to primary procedure)
   (Do not report 64495 more than once per day)

SYMPATHETIC NERVES

64505 Injection, anesthetic agent; sphenopalatine ganglion
64510 stellate ganglion (cervical sympathetic)
64517 superior hypogastric plexus
64520 lumbar or thoracic (paravertebral sympathetic)
64530 celiac plexus, with or without radiologic monitoring

NEUROSTIMULATORS (PERIPHERAL NERVE)

Codes 64553-64595 apply to both simple and complex neurostimulators. For initial or subsequent electronic analysis and programming of neurostimulator pulse generators, see codes 95970-95975.

64553 Percutaneous implantation of neurostimulator electrode array; cranial nerve
64555 peripheral nerve (excludes sacral nerve)
(Do not report 64555 in conjunction with 64566)
64561 sacral nerve (transforaminal placement) including image guidance, if performed
64566 Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming
(Do not report 64566 in conjunction with 64555, 95970-95972)
64568 Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
(Do not report 64568 in conjunction with 61885, 61886, 64570)
64569 Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
(Do not report 64569 in conjunction with 64570 or 61888)
64570 Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
(Do not report 64570 in conjunction with 61888)
64575 Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64580 neuromuscular
64581 sacral nerve (transforaminal placement)
64585 Revision or removal of peripheral neurostimulator electrode array
64590 Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
(Do not report 64590 in conjunction with 64595)
64595 Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver

DESTRUCTION BY NEUROLYTIC AGENT (EG, CHEMICAL, THERMAL, ELECTRICAL, 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
64624  Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed
64625  Radiofrequency ablation, nerves innervating the sacroiliac joint, with imaging guidance (ie, fluoroscopy or computed tomography)
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)
       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
       cervical or thoracic, each additional facet joint
       (List separately in addition to primary procedure)
       (Use 64634 in conjunction with 64633)
64635  lumbar or sacral, single facet joint
64636  lumbar or sacral, each additional facet joint
       (List separately in addition to primary procedure)
       (Use 64636 in conjunction with 64635)
       (Do not report 64633-64636 in conjunction with 77003, 77012)
       (For bilateral procedure, report 64633-64636 with modifier 50)
64640  other peripheral nerve or branch
64642  Chemodenervation of one extremity; 1-4 muscle(s)
64643  each additional extremity; 1-4 muscle(s) (List separately in addition to code for primary procedure)
64644  Chemodenervation of one extremity; 5 or more muscle(s)
64645  each additional extremity; 5 or more muscle(s) (List separately in addition to code for primary procedure)
64646  Chemodenervation of trunk muscle(s); 1-5 muscle(s)
64647  6 or more muscle(s)

SYMPATHETIC NERVES
64650  Chemodenervation of eccrine glands; both axillae
64653  other area(s) (eg, scalp, face, neck), per day
64680  Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus
64681  superior hypogastric plexus

NEUROPLASTY (EXPLORATION, NEUROLYSIS OR NERVE DECOMPRESSION)
Neuroplasty is the decompression or freeing of intact nerve from scar tissue, including external neurolysis and/or transposition.

64702  Neuroplasty; digital, one or both, same digit
64704  nerve of hand or foot
64708  Neuroplasty, major peripheral nerve, arm or leg, open; other than specified
64712  sciatic nerve
64713  brachial plexus
64714  lumbar plexus
64716  Neuroplasty and/or transposition; cranial nerve (specify)
64718  ulnar nerve at elbow
64719  ulnar nerve at wrist
64721  median nerve at carpal tunnel
64722  Decompression; unspecified nerve(s) (specify)
64726  plantar digital nerve
64727  Internal neurolysis, requiring use of operating microscope
   (List separately in addition to code for neuroplasty)
   (Neuroplasty includes external neurolysis)

TRANSECTION OR AVULSION

64732  Transection or avulsion of; supraorbital nerve
64734  infraorbital nerve
64736  mental nerve
64738  inferior alveolar nerve by osteotomy
64740  lingual nerve
64742  facial nerve, differential or complete
64744  greater occipital nerve
64746  phrenic nerve
64755  vagus nerve limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy)
64760  vagus nerve (vagotomy), abdominal
64763  Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy
64766  Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy
64771  Transection or avulsion of other cranial nerve, extradural
   (For procedures 64763, 64766, for bilateral procedure, use modifier -50)
64772  Transection or avulsion of other spinal nerve, extradural

EXCISION

SOMATIC NERVES

64774  Excision of neuroma; cutaneous nerve, surgically identifiable
64776  digital nerve, one or both, same digit
64778  digital nerve, each additional digit
   (List separately in addition to primary procedure)
   (Use 64778 in conjunction with 64776)
64782  hand or foot, except digital nerve
64783  hand or foot, each additional nerve, except same digit
   (List separately in addition to primary procedure)
   (Use 64783 in conjunction with 64782)
64784  major peripheral nerve, except sciatic
64786  sciatic nerve
64787  Implantation of nerve end into bone or muscle
   (List separately in addition to neuroma excision)
   (Use 64787 in conjunction with 64774-64786)
64788  Excision of neurofibroma or neurolemmoma; cutaneous nerve
64790  major peripheral nerve
64792  extensive (including malignant type)
64795  Biopsy of nerve

SYMPATHETIC NERVES

(For procedures 64802, 64804, 64809, 64818 for bilateral procedure, use modifier -50)

64802  Sympathectomy, cervical
64804  cervicothoracic
64809  thoracolumbar
64818  lumbar
64820  digital arteries, each digit
64821  radial artery
64822  ulnar artery
64823  superficial palmar arch

NEUORRHAPHY

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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>64862</td>
<td>lumbar plexus</td>
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<tr>
<td>64864</td>
<td>Suture of facial nerve; extracranial</td>
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<tr>
<td>64865</td>
<td>infratemporal, with or without grafting</td>
</tr>
<tr>
<td>64866</td>
<td>Anastomosis; facial-spinal accessory</td>
</tr>
<tr>
<td>64868</td>
<td>facial-hypoglossal</td>
</tr>
<tr>
<td>64872</td>
<td>Suture of nerve; requiring secondary or delayed suture</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary neurorrhaphy)</td>
</tr>
<tr>
<td>64874</td>
<td>requiring extensive mobilization, or transposition of nerve</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to code for nerve suture)</td>
</tr>
<tr>
<td>64876</td>
<td>requiring shortening of bone of extremity</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to code for nerve suture)</td>
</tr>
<tr>
<td></td>
<td>(Use 64872, 64874, 64876 in conjunction with 64831-64865)</td>
</tr>
</tbody>
</table>

**NEURORRHAPHY WITH NERVE GRAFT, VEIN GRAFT, OR CONDUIT**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64885</td>
<td>Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length</td>
</tr>
<tr>
<td>64886</td>
<td>more than 4 cm in length</td>
</tr>
<tr>
<td>64890</td>
<td>Nerve graft (includes obtaining graft), single strand hand or foot; up to 4 cm length</td>
</tr>
<tr>
<td>64891</td>
<td>more than 4 cm length</td>
</tr>
<tr>
<td>64892</td>
<td>Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length</td>
</tr>
<tr>
<td>64893</td>
<td>more than 4 cm length</td>
</tr>
<tr>
<td>64895</td>
<td>Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length</td>
</tr>
<tr>
<td>64896</td>
<td>more than 4 cm length</td>
</tr>
<tr>
<td>64897</td>
<td>Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length</td>
</tr>
<tr>
<td>64898</td>
<td>more than 4 cm length</td>
</tr>
<tr>
<td>64901</td>
<td>Nerve graft, each additional nerve; single strand</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 64901 in conjunction with 64885-64893)</td>
</tr>
<tr>
<td>64902</td>
<td>multiple strands (cable)</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 64902 in conjunction with 64885, 64886, 64895-64898)</td>
</tr>
<tr>
<td>64905</td>
<td>Nerve pedicle transfer; first stage</td>
</tr>
<tr>
<td>64907</td>
<td>second stage</td>
</tr>
<tr>
<td>64910</td>
<td>Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve</td>
</tr>
<tr>
<td>64911</td>
<td>with autogenous vein graft (includes harvest of vein graft), each nerve</td>
</tr>
</tbody>
</table>

**OTHER PROCEDURES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64999</td>
<td>Unlisted procedure, nervous system</td>
</tr>
</tbody>
</table>

**EYE AND OCULAR ADNEXA**

(For diagnostic and treatment ophthalmological services, see MEDICINE, Ophthalmology, and 92002 et seq)
REMOVAL OF EYE

65091 Evisceration of ocular contents; without implant
65093 with implant
65101 Enucleation of eye; without implant
65103 with implant, muscles not attached to implant
65105 with implant, muscles attached to implant
65110 Exenteration of orbit (does not include skin graft), removal of orbital contents; only
65112 with therapeutic removal of bone
65114 with muscle or myocutaneous flap

SECONDARY IMPLANT(S) PROCEDURES

An ocular implant is an implant inside muscular cone; an orbital implant is an implant outside muscular cone.

65125 Modification of ocular implant with placement or replacement of pegs (eg, drilling receptacle for prosthesis appendage) (separate procedure)
65130 Insertion of ocular implant secondary; after evisceration, in scleral shell
65135 after enucleation, muscles not attached to implant
65140 after enucleation, muscles attached to implant
65150 Reinsertion of ocular implant; with or without conjunctival graft
65155 with use of foreign material for reinforcement and/or attachment of muscles to implant
65175 Removal of ocular implant

REMOVAL OF FOREIGN BODY

65205 Removal of foreign body, external eye; conjunctival superficial
65210 conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
65220 corneal, without slit lamp
65222 corneal, with slit lamp
65235 Removal of foreign body, intraocular; from anterior chamber of eye or lens
65260 from posterior segment, magnetic extraction, anterior or posterior route
65265 from posterior segment, nonmagnetic extraction

REPAIR OF LACERATION

65270 Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure
65272 conjunctiva, by mobilization and rearrangement, without hospitalization
65273 conjunctiva, by mobilization and rearrangement, with hospitalization
65275 cornea, nonperforating, with or without removal foreign body
65280 cornea and/or sclera, perforating, not involving uveal tissue
65285 cornea and/or sclera, perforating, with reposition or resection of uveal tissue
65286 application of tissue glue, wounds of cornea and/or sclera
65290 Repair of wound, extraocular muscle, tendon and/or Tenon's capsule

ANTERIOR SEGMENT
**CORNEA**

**EXCISION**

65400 Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium
65410 Biopsy of cornea
65420 Excision or transposition of pterygium; without graft
65426 with graft

**REMOVAL OR DESTRUCTION**

65430 Scraping of cornea, diagnostic, for smear and/or culture
65435 Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)
65436 with application of chelating agent, eg, EDTA
65450 Destruction of lesion of cornea by cryotherapy, photocoagulation or thermocauterization
65600 Multiple punctures of anterior cornea (eg, for corneal erosion, tattoo)

**KERATOPLASTY**

Corneal transplant includes use of fresh or preserved grafts, and preparation of donor material. (Keratoplasty excludes refractive keratoplasty procedures 65760, 65765 and 65767)

65710 Keratoplasty (corneal transplant); anterior lamellar
65730 penetrating (except in aphakia or pseudophakia)
65750 penetrating (in aphakia)
65755 penetrating (in pseudophakia)
65756 endothelial

**OTHER PROCEDURES**

65778, 65779, 65780, 65781, 65782 are billable for patients with ocular surface deficiency, for those patients: who have sustained ocular burns and/or injuries OR; who have ocular complications secondary to Stevens-Johnson syndrome OR; who have undergone multiple surgeries or cryotherapies to the limbal region OR; who require these reconstructive procedures in addition to NYS Medicaid covered keratoplasty procedures OR; for whom medical management (lubricants, artificial tears, topical and systemic antibiotics, topical and systemic steroids, patches, etc.) has proven ineffective.

65760 Keratomileusis
65765 Keratophakia
65767 Epikeratoplasty
65770 Keratoprosthesis
65771 Radial keratotomy
65772 Corneal relaxing incision for correction of surgically induced astigmatism
65775 Corneal wedge resection for correction of surgically induced astigmatism
65778 Placement of amniotic membrane on the ocular surface; without sutures
65779 single layer, sutured
65780 Ocular surface reconstruction; amniotic membrane transplantation, multiple layers
65781 limbal stem allograft (eg, cadaveric or living donor)
65782  limbal conjunctival autograft (includes obtaining graft)

**ANTERIOR CHAMBER**

**INCISION**

65800  Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous
65810  with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection
65815  with removal of blood, with or without irrigation and/or air injection
65820  Goniotomy
   (Do not report modifier -63 in conjunction with 65820)
   (For use of ophthalmic endoscope with 65820, use 66990)
65850  Trabeculotomy ab externo
65855  Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)
65860  Severing adhesions of anterior segment, laser technique (separate procedure)
65865  Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); goniosynechiae
65870  anterior synechiae, except goniosynechiae
65875  posterior synechiae
   (For use of ophthalmic endoscope with 65875, use 66990)
65880  corneovitreal adhesions

**REMOVAL**

65900  Removal of epithelial downgrowth, anterior chamber of eye
65920  Removal of implanted material, anterior segment of eye
   (For use of ophthalmic endoscope with 65920, use 66990)
65930  Removal of blood clot, anterior segment of eye

**INTRODUCTION**

66020  Injection, anterior chamber of eye (separate procedure); air or liquid
66030  medication

**ANTERIOR SCLERA**

**EXCISION**

66130  Excision of lesion, sclera
66150  Fistulization of sclera for glaucoma; trephination with iridectomy
66155  thermocauterization with iridectomy
66160  sclerectomy with punch or scissors, with iridectomy
66170  trabeculectomy ab externo in absence of previous surgery
66172  trabeculectomy ab externo with scarring from previous ocular surgery or trauma
   (includes injection of antifibrotic agents)
66174  Transluminal dilation of aqueous outflow canal; without retention of device or stent
66175  with retention of device or stent

AQUEOUS SHUNT

66179  Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft
66180  with graft
66183  Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach
66184  Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft
66185  with graft

REPAIR OR REVISION

66225  Repair of scleral staphyoma 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, transsceral
66711  cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens
(Do not report 66711 in conjunction with 66990)
66720  cryotherapy
66740  cyclodialysis
66761  Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)
66762  Iridoplasty by photocoagulation (one or more sessions) (eg, for improvement of vision for widening of anterior chamber angle)
66770  Destruction of cyst or lesion iris or ciliary body (nonexcisional procedure)

LENS

INCISION
66820  Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)
66821  laser surgery (eg, YAG laser) (one or more stages)
66825  Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)

REMOVAL
Lateral canthotomy, iridectomy, iridotomy, anterior capsulotomy, posterior capsulotomy, the use of viscoelastic agents, enzymatic zonulysis, use of other pharmacologic agents, and subconjunctival or sub-tenon injections are included as part of the code for the extraction of lens.
66830  Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
66840  Removal of lens material; aspiration technique, one or more stages
66850  phacofragmentation technique (mechanical or ultrasonic,)
       (eg, phacoemulsification), with aspiration
66852  pars plana approach, with or without vitrectomy
66920  extracapsular
66930  extracapsular, for dislocated lens
66940  intracapsular

INTRAOCULAR LENS PROCEDURES
66982  Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhesis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation
66983  Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
66984  Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation
66985  Insertion of intraocular lens prosthesis (secondary implant) not associated with concurrent cataract removal
       (For use of ophthalmic endoscope with 66985, use 66990)
66986  Exchange of intraocular lens
(For use of ophthalmic endoscope with 66986, use 66990)

OTHER PROCEDURES

66990  Use of ophthalmic endoscope
(List separately in addition to primary procedure)
(66990 may be used only with codes 65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041, 67042, 67043, 67113)

66999  Unlisted procedure, anterior segment, eye

POSTERIOR SEGMENT

VITREOUS

67005  Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal
67010  subtotal removal with mechanical vitrectomy
67015  Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)
67025  Injection of vitreous substitute, pars plana or limbal approach, (fluid-gas exchange), with or without aspiration (separate procedure)
67027  Implantation of intravitreal drug delivery system (eg, Ganciclovir implant), includes concomitant removal of vitreous
67028  Intravitreal injection of a pharmacologic agent (separate procedure)
67030  Discission of vitreous strands (without removal), pars plana approach
67031  Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)
67036  Vitrectomy, mechanical, pars plana approach;
67039  with focal endolaser photocoagulation
67040  with endolaser panretinal photocoagulation
67041  with removal of preretinal cellular membrane (eg, macular pucker)
67042  with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)
67043  with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation

RETINA OR CHOROID

REPAIR
(If diathermy, cryotherapy and/or photocoagulation are combined, report under principal modality used)

67101  Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy
67105  photocoagulation
67107 Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation and drainage of subretinal fluid

67108 with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique

67110 by injection of air or other gas (eg, pneumatic retinopexy)

67113 Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens

67115 Release of encircling material (posterior segment)

67120 Removal of implanted material, posterior segment; extraocular

67121 intraocular

PROPHYLAXIS

Codes 67141, 67145, 67208-67220, 67227, 67228, 67229 include treatment at one or more sessions that may occur at different encounters. These codes should be reported once during a defined treatment period.

Repetitive services. The services listed below are often performed in multiple sessions or groups of sessions. The methods of reporting vary.

The following descriptors are intended to include all sessions in a defined treatment period.

67141 Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy

67145 photocoagulation (laser or xenon arc)

DESTRUCTION

67208 Destruction of localized lesion of retina (eg, macular edema, tumors) one or more sessions; cryotherapy, diathermy

67210 photocoagulation

67218 radiation by implantation of source (includes removal of source)

67220 Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), one or more sessions

67221 photodynamic therapy (includes intravenous infusion)

67225 photodynamic therapy, second eye, at single session (List separately in addition to primary eye treatment) (Use 67225 in conjunction with code 67221)

67227 Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; cryotherapy, diathermy

67228 Treatment of extensive or progressive retinopathy, one or more sessions; (eg, diabetic retinopathy), photocoagulation
67229  preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy (For bilateral procedure, use modifier 50)

**POSTERIOR SCLERAL**

**REPAIR**

67250  Scleral reinforcement (separate procedure); without graft
67255  with graft

**OTHER PROCEDURES**

67299  Unlisted procedure, posterior segment

**OCULAR ADNEXA**

**EXTRAOCULAR MUSCLES**

(Use 67320, 67331, 67332, 67334 in conjunction with 67311-67318)

(Use 67335, 67340, in conjunction with 67311-67334)

(Use 67343 in conjunction with 67311-67340, when such procedures are performed other than on the affected muscle)

(For adjustable sutures, use 67335 in addition to codes 67311-67334 for primary procedure reflecting number of muscles operated on)

67311  Strabismus surgery, recession or resection procedure; one horizontal muscle
67312  two horizontal muscles
67314  one vertical muscle (excluding superior oblique)
67316  two or more vertical muscles (excluding superior oblique)
67318  Strabismus surgery, any procedure superior oblique muscle
67320  Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify)
   (List separately in addition to primary procedure)
67331  Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles
   (List separately in addition to primary procedure)
67332  Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy)
   (List separately in addition to primary procedure)
67334  Strabismus surgery by posterior fixation suture technique, with or without muscle recession
   (List separately in addition to primary procedure)
67335  Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s)
   (List separately in addition to code for specific strabismus surgery)
67340  Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to primary procedure)
67343  Release of extensive scar tissue without detaching extraocular muscle (separate procedure)
67345  Chemodenervation of extraocular muscle
67346  Biopsy of extraocular muscle

OTHER PROCEDURES
67399  Unlisted procedure, extraocular muscle

ORBIT
EXPLORATION, EXCISION, DECOMPRESSION
67400  Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy
67405  with drainage only
67412  with removal of lesion
67413  with removal of foreign body
67414  with removal of bone for decompression
67415  Fine needle aspiration of orbital contents
67420  Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion
67430  with removal of foreign body
67440  with drainage
67445  with removal of bone for decompression
67450  for exploration, with or without biopsy

OTHER PROCEDURES
67500  Retrobulbar injection; medication (separate procedure, does not include supply of medication)
67505  alcohol
67515  Injection of medication or other substance into Tenon’s capsule
67550  Orbital implant (implant outside muscle cone); insertion
67560  removal or revision
67570  Optic nerve decompression (eg, incision or fenestration of optic nerve sheath)
67599  Unlisted procedure, orbit

EYELIDS
INCISION
67700  Blepharotomy, drainage of abscess, eyelid
67710  Severing of tarsorrhaphy
67715  Canthotomy (separate procedure)

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

67800 Excision of chalazion; single
67801 multiple, same lid
67805 multiple, different lids
67808 under general anesthesia and/or requiring hospitalization, single or multiple
67810 Incisional biopsy of eyelid skin including lid margin
67820 Correction of trichiasis; epilation, by forceps only
67825 epilation by other than forceps (e.g., 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 (e.g., Frost suture)
67880 Construction of intermarginal adhesions, median tarsorrhaphy, or canthorhaphy;
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 (e.g., 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-Müller’s muscle-levator resection (Fasanella-Servat type)
67909 Reduction of overcorrection of ptosis
67911 Correction of lid retraction
67912 Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)
67914 Repair of ectropion; suture
67915 thermocauterization
67916 excision tarsal wedge
67917 extensive (e.g., tarsal strip operations)
67921 Repair of entropion; suture
67922 thermocauterization
67923 excision tarsal wedge
67924 extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)

RECONSTRUCTION

Codes for blepharoplasty involve more than skin (i.e., involving lid margin, tarsus, and/or palpebral conjunctiva)
67930 Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva, direct closure; partial thickness
67935 full thickness
67938 Removal of embedded foreign body, eyelid
67950 Canthoplasty (reconstruction of canthus)
67961 Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one fourth of lid margin
67966 over one fourth of lid margin
67971 Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, one stage or first stage
67973 total eyelid, lower, one stage or first stage
67974 total eyelid, upper, one stage or first stage
67975 second stage

OTHER PROCEDURES
67999 Unlisted procedure, eyelids

CONJUNCTIVA

INCISION AND DRAINAGE
68020 Incision of conjunctiva, drainage of cyst
68040 Expression of conjunctival follicles (eg, for trachoma)

EXCISION AND/OR DESTRUCTION
68100 Biopsy of conjunctiva
68110 Excision of lesion, conjunctiva; up to 1 cm
68115 over 1 cm
68130 with adjacent sclera
68135 Destruction of lesion, conjunctiva

INJECTION
68200 Subconjunctival injection

CONJUNCTIVOPLASTY
68320 Conjunctivoplasty; with conjunctival graft or extensive rearrangement
68325 with buccal mucous membrane graft (includes obtaining graft)
68326 Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement
68328 with buccal mucous membrane graft (includes obtaining graft)
68330 Repair of symblepharon; conjunctivoplasty, without graft
68335 with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)
68340 division of symblepharon with or without insertion of conformer or contact lens
OTHER PROCEDURES

68360  Conjunctival flap; bridge or partial (separate procedure)
68362  total (such as Gunderson thin flap or purse string flap)
68399  Unlisted procedure, conjunctiva

LACRIMAL SYSTEM

INCISION

68400  Incision, drainage of lacrimal gland
68420  Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy)
68440  Snip incision of lacrimal punctum

EXCISION

68500  Excision of lacrimal gland (dacryoadenectomy), except for tumor; total
68505      partial
68510  Biopsy of lacrimal gland
68520  Excision of lacrimal sac (dacryocystectomy)
68525  Biopsy of lacrimal sac
68530  Removal of foreign body or dacryolith, lacrimal passages
68540  Excision of lacrimal gland tumor; frontal approach
68550      involving osteotomy

REPAIR

68700  Plastic repair of canaliculi
68705  Correction of everted punctum, cautery
68720  Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)
68745  Conjunctivohrinostomy (fistulization of conjunctiva to nasal cavity); without tube
68750      with insertion of tube or stent
68760  Closure of lacrimal punctum; by thermocauterization, ligation, or laser surgery
68761      by plug, each
68770  Closure of lacrimal fistula (separate procedure)

PROBING AND/OR RELATED PROCEDURES

(For codes 68801 – 68816, for bilateral procedures, use modifier -50)

68801  Dilation of lacrimal punctum, with or without irrigation
68810  Probing of nasolacrimal duct, with or without irrigation;
68811      requiring general anesthesia
68815      with insertion of tube or stent
     See also 92018
68816  Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation
     (Do not report 68816 in conjunction with 68810, 68811, 68815)
68840  Probing of lacrimal canaliculi, with or without irrigation
68850  Injection of contrast medium for dacryocystography

OTHER PROCEDURES

68899  Unlisted procedure, lacrimal system

AUDITORY SYSTEM

EXTERNAL EAR

INCISION

69000  Drainage external ear, abscess or hematoma; simple
69005  complicated
69020  Drainage external auditory canal, abscess

EXCISION

69100  Biopsy external ear
69105  Biopsy external auditory canal
69110  Excision external ear; partial, simple repair
69120  complete amputation
69140  Excision exostosis(es), external auditory canal
69145  Excision soft tissue lesion, external auditory canal
69150  Radical excision external auditory canal lesion; without neck dissection
69155  with neck dissection

REMOVAL

(For codes 69220, 69222, for bilateral procedures use modifier -50)

69200  Removal foreign body from external auditory canal; without general anesthesia
69205  with general anesthesia
69210  Removal impacted cerumen requiring instrumentation (report one unit for unilateral OR bilateral procedure)
69220  Debridement, mastoidectomy cavity, simple (eg, routine cleaning)
69222  Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)

REPAIR

69300  Otoplasty, protruding ear, with or without size reduction
(For bilateral procedure, report 69300 with modifier 50)
69310  Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection), separate procedure
69320  Reconstruction of external auditory canal for congenital atresia, single stage

OTHER PROCEDURES
69399  Unlisted procedure, external ear

**MIDDLE EAR**

**INCISION**

(For codes 69433, 69436, for bilateral procedures use modifier -50)

69420  Myringotomy including aspiration and/or eustachian tube inflation
69421  Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia
69424  Ventilating tube removal requiring general anesthesia
69433  Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia
69436  Tympanostomy (requiring insertion of ventilating tube), general anesthesia
69440  Middle ear exploration through postauricular or ear canal incision
69450  Tympanolysis, transcanal

**EXCISION**

69501  Transmastoid antrotomy (simple mastoidectomy)
69502  Mastoidectomy; complete
69505     modified radical
69511     radical
69530  Petrous apicectomy including radical mastoidectomy
69535  Resection temporal bone, external approach
69540  Excision aural polyp
69550  Excision aural glomus tumor; transcanal
69552     transmastoid
69554     extended (extratemporal)

**REPAIR**

69601  Revision mastoidectomy; resulting in complete mastoidectomy
69602     resulting in modified radical mastoidectomy
69603     resulting in radical mastoidectomy
69604     resulting in tympanoplasty
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  Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
69632     with ossicular chain reconstruction, (eg, postfenestration)
69633     with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, (PORP), total ossicular replacement prosthesis, (TORP))
69635  Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction
69636  with ossicular chain reconstruction
69637  with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, (PORP), total ossicular replacement prosthesis, (TORP))
69641  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
69649  Stapes mobilization
69650  Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;
69660  with footplate drill out
69662  Revision of stapedectomy or stapedotomy
69663  Repair oval window fistula
69667  Repair round window fistula
69670  Mastoid obliteration (separate procedure)
69676  Tympanic neurectomy
(For bilateral procedure, use modifier -50)

**OTHER PROCEDURES**

69700  Closure postauricular fistula, mastoid (separate procedure)
69710  Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone
(Replacement procedure includes removal of old device)
69711  Removal or repair of electromagnetic bone conduction hearing device in temporal bone
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