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 [http://www.emedny.org/ProviderManuals/Physician/index.html](http://www.emedny.org/ProviderManuals/Physician/index.html)
   
   Listed fees are the maximum reimbursable Medicaid fees. Fees for the MOMS Program can be found in the Enhanced Program fee schedule. Fees for office, home and hospital visits, consultations and other medical services are listed in the Fee Schedule entitled MEDICINE.

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

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

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

4. **ADDITIONAL SERVICES:**
   
   Complications or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional charges on a fee-for-service basis. (See modifiers -24, -25, -79). 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, 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, 58220, 58240, 58260, 58262, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58545, 58546, 58547, 58548, 58550, 58552, 58553, 58554, 58555, 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; without imaging guidance
10022 with imaging guidance

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

EXCISION – DEBRIDEMENT
11000 Debridement of extensive eczematous or infected skin; up to 10% of body surface
11001 each additional 10% of the body surface, or part thereof
(List separately in addition to primary procedure)
(Use 11001 in conjunction with 11000)
11004 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum
11005 abdominal wall, with or without fascial closure
11006 external genitalia, perineum and abdominal wall, with or without fascial closure
11008 Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection)
(List separately in addition to primary procedure)
(Use 11008 in conjunction with 10180, 11004-11006)
(Do not report 11008 in conjunction with 11000-11001, 11010-11044)
(Report skin grafts or flaps separately when performed for closure at the same session as 11004-11008)

11010 Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues

11011 skin, subcutaneous tissue, muscle fascia, and muscle
11012 skin, subcutaneous tissue, muscle fascia, muscle, and bone

11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less

11043 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less

11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle, and/or fascia, if performed); first 20 sq cm or less

11045 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof
(List separately in addition to primary procedure)
(Use 11045 in conjunction with 11042)

11046 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof
(List separately in addition to primary procedure)
(Use 11046 in conjunction with 11043)

11047 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle, and/or fascia, if performed); each additional 20 sq cm, or part thereof
(List separately in addition to primary procedure)
(Use 11047 in conjunction with 11044)

**PARING OR CUTTING**

11055 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion

11056 two to four lesions

11057 more than four lesions

**BIOPSY**

During certain surgical procedures in the integumentary system, such as excision, destruction, or shave removals, the removed tissue is often submitted for pathologic examination. The obtaining of tissue for pathology during the course of these procedures is a routine component of such procedures. This obtaining of tissue is not considered a separate biopsy procedure and is not separately reported. The use of a biopsy procedure code (eg, 11100, 11101) indicates that the procedure to obtain tissue for pathologic examination was performed independently, or was unrelated or distinct from other procedures/services provided at that time. Such biopsies are not considered
components of other procedures when performed on different lesions or different sites on the same date, and are to be reported separately.

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

REMOVAL OF SKIN TAGS

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

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

SHAVING OF EPIDERMAL OR DERMAL LESIONS

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

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

EXCISION – BENIGN LESIONS

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</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>
</tr>
<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>
</tr>
<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>
</tr>
<tr>
<td>11421</td>
<td>excised diameter 0.6 to 1.0 cm</td>
</tr>
<tr>
<td>11422</td>
<td>excised diameter 1.1 to 2.0 cm</td>
</tr>
<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>
</tr>
<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>
</tr>
<tr>
<td>11442</td>
<td>excised diameter 1.1 to 2.0 cm</td>
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<tr>
<td>11443</td>
<td>excised diameter 2.1 to 3.0 cm</td>
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<tr>
<td>11444</td>
<td>excised diameter 3.1 to 4.0 cm</td>
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<tr>
<td>11446</td>
<td>excised diameter over 4.0 cm</td>
</tr>
<tr>
<td>11450</td>
<td>Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair</td>
</tr>
<tr>
<td>11451</td>
<td>with complex repair</td>
</tr>
<tr>
<td>11462</td>
<td>Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair</td>
</tr>
<tr>
<td>11463</td>
<td>with complex repair</td>
</tr>
<tr>
<td>11470</td>
<td>Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal or umbilical; with simple or intermediate repair</td>
</tr>
<tr>
<td>11471</td>
<td>with complex repair</td>
</tr>
</tbody>
</table>
EXCISION - MALIGNANT LESIONS

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

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

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

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

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

11600  Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 0.5 cm or less
11601  excised diameter 0.6 to 1.0 cm
11602  excised diameter 1.1 to 2.0 cm
11603  excised diameter 2.1 to 3.0 cm
11604  excised diameter 3.1 to 4.0 cm
11606  excised diameter over 4.0 cm
11620  Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11621  excised diameter 0.6 to 1.0 cm
11622  excised diameter 1.1 to 2.0 cm
11623  excised diameter 2.1 to 3.0 cm
11624  excised diameter 3.1 to 4.0 cm
11626  excised diameter over 4.0 cm
11640  Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less
11641  excised diameter 0.6 to 1.0 cm
11642  excised diameter 1.1 to 2.0 cm
11643  excised diameter 2.1 to 3.0 cm
11644  excised diameter 3.1 to 4.0 cm
11646  excised diameter over 4.0 cm

**NAILS**

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

**PILONIDAL CYST**

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

**INTRODUCTION**

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

**REPAIR (CLOSURE)**

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

**DEFINITIONS:**

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

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

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

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

Instructions for listing services at time of wound repair:

1. The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular or stellate.
2. When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and from all anatomic sites that are grouped together into the same code descriptor. For example, add together the lengths of intermediate repairs to the trunk and extremities. Do not add lengths of repairs from different groupings of anatomic sites (eg, face and extremities). Also, do not add together lengths of different classifications (eg, intermediate and complex repairs).
3. Decontamination and/or debridement: Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure. (For extensive debridement of soft tissue and/or bone, see 11044)
(For extensive debridement of soft tissue and/or bone, not associated with open fracture(s) and/or dislocation(s) resulting from penetrating and/or blunt trauma, see 11044.)
(For extensive debridement of subcutaneous tissue, muscle fascia, muscle, and/or bone associated with open fracture(s) and/or dislocation(s), see 11010-11012.)

4. Involvement of nerves, blood vessels and tendons: Report under appropriate system (Nervous, Cardiovascular, Musculoskeletal) for repair of these structures. The repair of these associated wounds is included in the primary procedure.

Simple ligation of vessels in an open wound is considered as part of any wound closure.
Simple exploration of nerves, blood vessels or tendons exposed in an open wound is also considered part of the essential treatment of the wound and is not a separate procedure unless appreciable dissection is required. If the wound requires enlargement, extension of dissection (to determine penetration), debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s), of the subcutaneous tissue, muscle, fascia, and/or muscle, not requiring thoracotomy or laparotomy, use codes 20100-20103, as appropriate.

**REPAIR-SIMPLE**

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

**REPAIR-INTERMEDIATE**

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

REPAIR-COMPLEX

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

ADJACENT TISSUE TRANSFER OR REARRANGEMENT

Excision (including lesion) and/or repair by adjacent tissue transfer or rearrangement (eg, Z-plasty, W-plasty, V-Y plasty, rotation flap, advancement flap, double pedicle flap). When applied in repairing lacerations, the procedures listed must be developed by the surgeon to accomplish the repair. They do not apply when direct closure or rearrangement of traumatic wounds incidentally result in these configurations.
Skin graft necessary to close secondary defect is considered an additional procedure. For purposes of code selection, the term “defect” includes the primary and secondary defects. The primary defect resulting from the excision and the secondary defect resulting from flap design to perform the reconstruction are measured together to determine the code.

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

**SKIN REPLACEMENT SURGERY**

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

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

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

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

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

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

15003 each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children

(List separately in addition to primary procedure)
(Use 15003 in conjunction with 15002)

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

15005 each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children

(List separately in addition to primary procedure)
(Use 15005 in conjunction with 15004)
(Report 15002-15005 in conjunction with code for appropriate skin grafts or replacements [15050-15261,]. List the graft or replacement separately by its procedure number when the graft, immediate or delayed, is applied)

**AUTOGRAFT/TISSUE CULTURED AUTOGRRAFT**

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

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

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

15101 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof

(List separately in addition to primary procedure)
(Use 15101 in conjunction with 15100)

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

15111 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof

(List separately in addition to primary procedure)
(Use 15111 in conjunction with 15110)

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

15116 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof

(List separately in addition to primary procedure)
(Use 15116 in conjunction with 15115)

15120 Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)
15121 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(ListNode 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
(ListNode 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
(ListNode 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
(ListNode 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
(ListNode 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
(ListNode 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
(ListNode 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
(ListNode separately in addition to primary procedure)
(Use 15201 in conjunction with 15200)

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

15221 each additional 20 sq cm, or part thereof
(ListNode 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
15731  Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)
15732  Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)
15734   trunk
15736   upper extremity
15738   lower extremity

Codes 15732-15738 are described by donor site of the muscle, myocutaneous, or fasciocutaneous flap.

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
dermal
15789 Chemical peel, nonfacial; epidermal
dermal
15792 Cervicoplasty
15793 Blepharoplasty, lower eyelid;
15821 with extensive herniated fat pad
15822 Blepharoplasty, upper eyelid;
15823 with excessive skin weighting down lid
   (For bilateral blepharoplasty, add modifier 50)
15824 Rhytidectomy; forehead
   (For bilateral rhytidectomy, add modifier 50)
15825 neck with platysmal tightening (platysmal flap, P-flap)
15826 glabellar frown lines
15828 cheek, chin, and neck
15829 superficial musculoaponeurotic system (SMAS) flap
15830 Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen,
   infraumbilical panniculectomy
   (Do not report 15830 in conjunction with 12031, 12032, 12034, 12035, 12036, 12037, 13100,
   13101, 13102, 14000-14001, 14302)
15832 thigh
15833 leg
15834 hip
15835 buttock
15836 arm
15837 forearm or hand
15838 submental fat pad
15839 other area
   (For bilateral procedure, add modifier 50)
15840 Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)
   (For bilateral procedure, add modifier 50)
15841 free muscle graft (including obtaining graft)
15842 free muscle flap by microsurgical technique
15845 regional muscle transfer
15847 Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg,
   abdominoplasty) (includes umbilical transposition and fascial plication)
(List separately in addition to primary procedure)
(Use 15847 in conjunction with 15830)

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

PRESSURE ULCERS (DECUBITIS ULCERS)

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

BURNS, LOCAL TREATMENT

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

List percentage of body surface involved and depth of burn.

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

DESTRUCTION

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

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

DESTRUCTION, BENIGN OR PREMALIGNANT LESIONS

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

DESTRUCTION, MALIGNANT LESIONS, ANY METHOD

17260  Destruction, malignant lesion, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less
17261  lesion diameter 0.6 to 1.0 cm
17262  lesion diameter 1.1 to 2.0 cm
17263  lesion diameter 2.1 to 3.0 cm
17264  lesion diameter 3.1 to 4.0 cm
17266  lesion diameter over 4.0 cm
17270  Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
MOHS’ MICROGRAPHIC SURGERY

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

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

17311 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks

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

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

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

17315 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by
the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and
eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (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 19260-19272 are not restricted to breast tumors and are used to report resections of chest wall tumors originating from any chest wall component.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>19081</td>
<td>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</td>
</tr>
<tr>
<td>19082</td>
<td>each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>19083</td>
<td>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</td>
</tr>
<tr>
<td>19084</td>
<td>each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>19085</td>
<td>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</td>
</tr>
<tr>
<td>19086</td>
<td>each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>19100</td>
<td>Biopsy of breast; percutaneous, needle core, not using needle guidance (separate procedure)</td>
</tr>
<tr>
<td>19101</td>
<td>open, incisional</td>
</tr>
<tr>
<td>19105</td>
<td>Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma (Do not report 19105 in conjunction with 76940, 76942)</td>
</tr>
<tr>
<td>19110</td>
<td>Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct</td>
</tr>
<tr>
<td>19112</td>
<td>Excision of lactiferous duct fistula</td>
</tr>
<tr>
<td>19120</td>
<td>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</td>
</tr>
<tr>
<td>19125</td>
<td>Excision of breast lesion identified by pre-operative placement of radiological marker, open; single lesion</td>
</tr>
<tr>
<td>19126</td>
<td>each additional lesion separately identified by a preoperative radiological marker (List separately in addition to primary procedure) (Use 19126 in conjunction with code 19125)</td>
</tr>
<tr>
<td>19260</td>
<td>Excision of chest wall tumor including ribs</td>
</tr>
<tr>
<td>19271</td>
<td>Excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy</td>
</tr>
<tr>
<td>19272</td>
<td>with mediastinal lymphadenectomy (Do not report 19260, 19271, 19272 in conjunction with 32100, 32503, 32504, 32551, 32554, 32555)</td>
</tr>
</tbody>
</table>

**INTRODUCTION**
19281 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including mammographic guidance
19282 each additional lesion, including mammographic guidance
   (List separately in addition to primary procedure)
19283 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including stereotactic guidance
19284 each additional lesion, including stereotactic guidance
   (List separately in addition to primary procedure)
19285 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including ultrasound guidance
19286 each additional lesion, including ultrasound guidance
   (List separately in addition to primary procedure)
19287 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including magnetic resonance guidance
19288 each additional lesion, including magnetic resonance guidance
   (List separately in addition to primary procedure)
19296 Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy
19297 concurrent with partial mastectomy
   (List separately in addition to primary procedure)
   (Use 19297 in conjunction with code 19301 or 19302)
19298 Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance

**MASTECTOMY PROCEDURES**

19300 Mastectomy for gynecomastia
19301 Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);
   with axillary lymphadenectomy
19303 Mastectomy, simple, complete
19304 Mastectomy, subcutaneous
19305 Mastectomy, radical, including pectoral muscles, axillary lymph nodes
19306 Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes
   (Urban type operation)
19307 Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

**REPAIR AND/OR RECONSTRUCTION**

(To report bilateral procedures, use modifier -50)

19316 Mastopexy (unilateral)
19318 Reduction mammaplasty (unilateral)
19324 Mammaplasty, augmentation; without prosthetic implant
19325 with prosthetic implant
19328 Removal of intact mammary implant
19330 Removal of implant material
19340 Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342 Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350 Nipple/areola reconstruction
19355 Correction of inverted nipples
19357 Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361 Breast reconstruction with latissimus dorsi flap, without prosthetic implant
19364 Breast reconstruction with free flap
   (19364 includes harvesting of the flap, microvascular transfer, closure of the donor site, and inset shaping the flap into a breast)
19366 Breast reconstruction with other technique
19367 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
19368 with microvascular anastomosis (supercharging)
19369 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
19370 Open periprosthetic capsulotomy, breast
19371 Periprosthetic capsulectomy, breast
19380 Revision of reconstructed breast
19396 Preparation of moulage for custom breast implant

OTHER PROCEDURES

19499 Unlisted procedure, breast

MUSCULOSKELETAL SYSTEM

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

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

DEFINITIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**GENERAL INCISION**

20005 Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)

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

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

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

**EXCISION**

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

**INTRODUCTION OR REMOVAL**

20500 Injection of sinus tract; therapeutic (separate procedure)
20501 diagnostic (sinogram)
20520 Removal of foreign body in muscle, or tendon sheath, simple
20525 deep or complicated
20526 Injection, therapeutic (eg, local anesthetic; corticosteroid), carpal tunnel
20527 Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren’s contracture)
20550 Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar “fascia”)
20551 single tendon origin/insertion
20552 single or multiple trigger point(s), one or two muscle(s)
20553 single or multiple trigger point(s), three or more muscle(s)
20555 Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radionelement application (at the time of or subsequent to the procedure)
20600 Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance
20604 with ultrasound guidance, with permanent recording and reporting
20605 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa
Physician - Procedure Codes, Section 5 - Surgery

(eg, tempomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance
20606 with ultrasound guidance, with permanent recording and reporting
20610 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
20611 with ultrasound guidance, with permanent recording and reporting
20612 Aspiration and/or injection of ganglion cyst(s) any location
20615 Aspiration and injection for treatment of bone cyst
20650 Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)
20660 Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)
20661 Application of halo, including removal; cranial
20662 pelvic
20663 femoral
20664 Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta)
20665 Removal of tongs or halo applied by another individual
20670 Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)
20680 deep, (eg, buried wire, pin, screw, metal band, nail, rod or plate)
20690 Application of a uniplane (pins or wires in one plane), unilateral, external fixation system
20692 Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)
20693 Adjustment or revision of external fixation system requiring anesthesia (eg, new pin(s) or wire(s), and/or new ring(s) or bar(s))
20694 Removal, under anesthesia, of external fixation system

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

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

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

- **20900** Bone graft, any donor area; minor or small (eg, dowel or button)
- **20902** major or large
- **20910** Cartilage graft; costochondral
- **20912** nasal septum
- **20920** Fascia lata graft; by stripper
- **20922** by incision and area exposure, complex or sheet
- **20924** Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)
- **20926** Tissue grafts, other (eg, paratenon, fat, dermis)
- **20931** Allograft, structural, for spine surgery only
  (List separately in addition to primary procedure)
  (Use 20931 in conjunction with 22319, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812)
- **20937** morselized (through separate skin or fascial incision)
  (List separately in addition to primary procedure)
  (Use 20937 in conjunction with 22319, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812)
- **20938** structural, bicortical or tricortical (through separate skin or fascial incision)
  (List separately in addition to code for primary procedure)
  (Use 20938 in conjunction with 22319, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812)
  (Codes 20931-20938 are reported in addition to codes for the definitive procedure(s). (Report only one bone graft code per operative session.)

**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

HEd

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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21142</td>
<td>two pieces, segment movement in any direction, without bone graft</td>
</tr>
<tr>
<td>21143</td>
<td>three or more pieces, segment movement in any direction, without bone graft</td>
</tr>
<tr>
<td>21145</td>
<td>single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)</td>
</tr>
<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>
</tbody>
</table>
21215  mandible (includes obtaining graft)
21230  Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235  ear cartilage, autograft, to nose or ear (includes obtaining graft)
21240  Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
21242  Arthroplasty, temporomandibular joint, with allograft
21243  Arthroplasty, temporomandibular joint, with prosthetic joint replacement
21244  Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
21245  Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246  complete
21247  Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
21248  Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
21249  complete
21255  Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256  Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, for hemifacial microsomia)
21260  Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261  combined intra- and extracranial approach
21263  with forehead advancement
21267  Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268  combined intra- and extracranial approach
21270  Malar augmentation, prosthetic material
21275  Secondary revision of orbitocraniofacial reconstruction
21280  Medial canthopexy (separate procedure)
21282  Lateral canthopexy
21295  Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach
21296  intraoral approach

OTHER PROCEDURES

21299  Unlisted craniofacial and maxillofacial procedure

FRACTURE AND/OR DISLOCATION

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

OTHER PROCEDURES

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

NECK (SOFT TISSUES) AND THORAX

INCISION

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

EXCISION

21550  Biopsy, soft tissue of neck or thorax
21552  Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater
21554  Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater
21555  Excision tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm
21556  subfascial (eg, intramuscular); less than 5 cm
21557  Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm
21558  5 cm or greater
21600  Excision of rib, partial
21610  Costotransversectomy (separate procedure)
21615  Excision first and/or cervical rib;
21616  with sympathectomy
21620 Ostectomy of sternum, partial
21627 Sternal debridement
21630 Radical resection of sternum;
21632 with mediastinal lymphadenectomy

REPAIR, REVISION AND/OR RECONSTRUCTION

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

FRACTURE AND/OR DISLOCATION

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

OTHER PROCEDURES

21899 Unlisted procedure, neck or thorax

BACK AND FLANK

EXCISION

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

SPINE (VERTEBRAL COLUMN)

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

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

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

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

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


**INCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22010</td>
<td>Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic</td>
</tr>
<tr>
<td>22015</td>
<td>Lumbar, sacral, or lumbosacral</td>
</tr>
<tr>
<td></td>
<td>(Do not report 22015 in conjunction with 22010)</td>
</tr>
<tr>
<td></td>
<td>(Do not report 22015 in conjunction with instrumentation removal, 10180, 22850, 22852)</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22100</td>
<td>Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical</td>
</tr>
</tbody>
</table>
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, 22220-22224, and
   63001-63048, 63055-63066, 63075-63091, 63101-63103, when performed at the same level)
22210 Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; cervical
22212 thoracic
22214 lumbar
22216 each additional segment
   (List separately in addition to primary procedure)
   (Use 22216 in conjunction with 22210, 22212, 22214)
22220 Osteotomy of spine, including discectomy, anterior approach, single vertebral segment;
cervical
22222 thoracic
22224 lumbar
22226 each additional segment
   (List separately in addition to primary procedure)
   (Use 22226 only for codes 22220, 22222, 22224)
FRACTURE AND/OR DISLOCATION

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

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

MANIPULATION

22505 Manipulation of spine requiring anesthesia, any region

PERCUTANEOUS VEREBROPLASTY and VERTEBRAL AUGMENTATION

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

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

ARTHRODESIS

LATERAL EXTRACAVITARY APPROACH TECHNIQUE

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

ANTERIOR OR ANTEROLATERAL APPROACH TECHNIQUE

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

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

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

22548  Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process
22551  Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552   cervical below C2, each additional interspace
   (List separately in addition to primary procedure)
22554  Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
22556   thoracic
22558   lumbar
22585  each additional interspace
   (List separately in addition to primary procedure)
   (Use 22585 in conjunction with 22554, 22556, 22558)
22586  Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace

**POSTERIOR, POSTEROLATERAL OR LATERAL TRANSVERSE PROCESS TECHNIQUE**

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

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

**SPINE DEFORMITY (EG, SCOLIOSIS, KYPHOSIS)**

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

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

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

EXPLORATION

22830  Exploration of spinal fusion

SPINAL INSTRUMENTATION

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

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

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

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

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

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

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

22840  Posterior non-segmental instrumentation (eg, Harrington Rod Technique), pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation (List separately in addition to primary procedure)
22842  Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to primary procedure)
22843  7 to 12 vertebral segments (List separately in addition to primary procedure)
22844  13 or more vertebral segments
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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) |
| 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  
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 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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22899</td>
<td>Unlisted procedure, spine</td>
</tr>
</tbody>
</table>
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>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</td>
</tr>
<tr>
<td></td>
<td>ligament release</td>
</tr>
<tr>
<td>23140</td>
<td>Excision or curettage of bone cyst or benign tumor of clavicle or scapula;</td>
</tr>
<tr>
<td>23145</td>
<td>with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>23146</td>
<td>with allograft</td>
</tr>
<tr>
<td>23150</td>
<td>Excision or curettage of bone cyst or benign tumor of proximal humerus;</td>
</tr>
<tr>
<td>23155</td>
<td>with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>23156</td>
<td>with allograft</td>
</tr>
<tr>
<td>23170</td>
<td>Sequestrectomy (eg, for osteomyelitis or bone abscess); clavicle</td>
</tr>
<tr>
<td>23172</td>
<td>scapula</td>
</tr>
<tr>
<td>23174</td>
<td>humeral head to surgical neck</td>
</tr>
<tr>
<td>23180</td>
<td>Partial excision (craterization, saucerization, or diaphysectomy) bone</td>
</tr>
<tr>
<td></td>
<td>(eg, osteomyelitis); clavicle</td>
</tr>
<tr>
<td>23182</td>
<td>scapula</td>
</tr>
<tr>
<td>23184</td>
<td>proximal humerus</td>
</tr>
<tr>
<td>23190</td>
<td>Ostectomy of scapula, partial (eg, superior medial angle)</td>
</tr>
<tr>
<td>23195</td>
<td>Resection humeral head</td>
</tr>
<tr>
<td>23200</td>
<td>Radical resection of tumor; clavicle</td>
</tr>
<tr>
<td>23210</td>
<td>scapula</td>
</tr>
<tr>
<td>23220</td>
<td>Radical resection of tumor, proximal humerus</td>
</tr>
</tbody>
</table>

**INTRODUCTION OR REMOVAL**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>23330</td>
<td>Removal of foreign body, shoulder; subcutaneous</td>
</tr>
<tr>
<td>23333</td>
<td>deep (subfascial or intramuscular)</td>
</tr>
<tr>
<td>23334</td>
<td>Removal of prosthesis, includes debridement and synovectomy when performed;</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>arthrography</td>
</tr>
</tbody>
</table>

**REPAIR, REVISION AND/OR RECONSTRUCTION**

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

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

**MANIPULATION**

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

**ARTHRODESIS**

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

**AMPUTATION**

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

**OTHER PROCEDURES**

23929  Unlisted procedure, shoulder

**HUMERUS (UPPER ARM) AND ELBOW**

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

**INCISION**

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

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

**INTRODUCTION OR REMOVAL**

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

24300  Manipulation, elbow, under anesthesia
24301  Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)
24305  Tendon lengthening, upper arm or elbow, each tendon
24310  Tenotomy, open, elbow to shoulder, each tendon
24320  Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)
24330  Flexor-plasty, elbow, (eg, Steindler type advancement);
24331          with extensor advancement
24332  Tenolysis, triceps
24340  Tenodesis of biceps tendon at elbow (separate procedure)
24341  Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)
24342  Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
24343  Repair lateral collateral ligament, elbow, with local tissue
24344  Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24345  Repair medial collateral ligament, elbow, with local tissue
24346  Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24357  Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous
24358  Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open
24359  Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment
24360  Arthroplasty, elbow; with membrane (eg, fascial)
24361          with distal humeral prosthetic replacement
24362          with implant and fascia lata ligament reconstruction
24363          with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)
24365  Arthroplasty, radial head;
24366          with implant
24370  Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component
24371          humeral and ulnar component
24400  Osteotomy, humerus, with or without internal fixation
24410  Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)
24420  Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876)
24430  Repair of nonunion or malunion, humerus; without graft (eg, compression technique, etc)
24435          with iliac or other autograft (includes obtaining graft)
24470  Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus)
24495  Decompression fasciotomy, forearm, with brachial artery exploration
24498 Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, humeral shaft

FRACTURE AND/OR DISLOCATION

24500 Closed treatment of humeral shaft fracture; without manipulation
24505 with manipulation, with or without skeletal traction
24515 Open treatment of humeral shaft fracture with plate/screws, with or without cerclage
24516 Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws
24530 Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; without manipulation
24535 with manipulation, with or without skin or skeletal traction
24538 Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension
24545 Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension
24546 with intercondylar extension
24550 Closed treatment of humeral epicondylar fracture, medial or lateral; without manipulation
24555 with manipulation
24565 Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation
24570 Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed
24575 Closed treatment of humeral condylar fracture, medial or lateral; without manipulation
24576 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)
24590 Treatment of closed elbow dislocation; without anesthesia
24595 requiring anesthesia
24600 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**

Version 2017
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25065</td>
<td>Biopsy, soft tissue; superficial</td>
</tr>
<tr>
<td>25066</td>
<td>deep (subfascial or intramuscular)</td>
</tr>
<tr>
<td>25071</td>
<td>Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater</td>
</tr>
<tr>
<td>25073</td>
<td>Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater</td>
</tr>
<tr>
<td>25075</td>
<td>Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm</td>
</tr>
<tr>
<td>25076</td>
<td>Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm</td>
</tr>
<tr>
<td>25077</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; less than 3 cm</td>
</tr>
<tr>
<td>25078</td>
<td>3 cm or greater</td>
</tr>
<tr>
<td>25085</td>
<td>Capsulotomy, wrist (eg, for contracture)</td>
</tr>
<tr>
<td>25100</td>
<td>Arthrotonomy, wrist joint; with biopsy</td>
</tr>
<tr>
<td>25101</td>
<td>with joint exploration, with or without biopsy, with or without removal of loose or foreign body</td>
</tr>
<tr>
<td>25105</td>
<td>with synovectomy</td>
</tr>
<tr>
<td>25107</td>
<td>Arthrotonomy, distal radioulnar joint including repair of triangular cartilage, complex</td>
</tr>
<tr>
<td>25109</td>
<td>Excision of tendon, forearm and/or wrist, flexor or extensor, each</td>
</tr>
<tr>
<td>25110</td>
<td>Excision, lesion of tendon sheath</td>
</tr>
<tr>
<td>25111</td>
<td>Excision of ganglion, wrist (dorsal or volar); primary</td>
</tr>
<tr>
<td>25112</td>
<td>recurrent</td>
</tr>
<tr>
<td>25115</td>
<td>Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors</td>
</tr>
<tr>
<td>25116</td>
<td>extensors (with or without transposition of dorsal retinaculum)</td>
</tr>
<tr>
<td>25118</td>
<td>Synovectomy, extensor tendon sheath, wrist, single compartment;</td>
</tr>
<tr>
<td>25119</td>
<td>with resection of distal ulna</td>
</tr>
<tr>
<td>25120</td>
<td>Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process);</td>
</tr>
<tr>
<td>25125</td>
<td>with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>25126</td>
<td>with allograft</td>
</tr>
<tr>
<td>25130</td>
<td>Excision or curettage of bone cyst or benign tumor of carpal bones;</td>
</tr>
<tr>
<td>25135</td>
<td>with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>25136</td>
<td>with allograft</td>
</tr>
<tr>
<td>25145</td>
<td>Sequestrectomy (eg, for osteomyelitis or bone abscess)</td>
</tr>
<tr>
<td>25150</td>
<td>Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis); ulna</td>
</tr>
<tr>
<td>25151</td>
<td>radius</td>
</tr>
<tr>
<td>25170</td>
<td>Radical resection for tumor, radius or ulna</td>
</tr>
<tr>
<td>25210</td>
<td>Carpectomy; one bone</td>
</tr>
<tr>
<td>25215</td>
<td>all bones of proximal row</td>
</tr>
<tr>
<td>25230</td>
<td>Radial styloidyectomy (separate procedure)</td>
</tr>
<tr>
<td>25240</td>
<td>Excision distal ulna partial or complete (eg, Darrach type or matched resection)</td>
</tr>
</tbody>
</table>

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

**REPAIR, REVISION AND/OR RECONSTRUCTION**

<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) (eg, for exterior carpi ulnaris subluxation)</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>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; with tendon(s) transfer</td>
</tr>
<tr>
<td>25320</td>
<td>Capsulorrhaphy or reconstruction, wrist, open, (eg, capsulodesis, ligament repair, tendon transfer or 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 soft tissue stabilization (eg, tendon transfer, tendon graft or weave, or tenodesis) with or 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 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>
<tr>
<td>Code</td>
<td>Description</td>
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</tr>
<tr>
<td>25391</td>
<td>lengthening with autograft</td>
</tr>
<tr>
<td>25392</td>
<td>Osteoplasty, radius AND ulna; shortening (excluding 64876)</td>
</tr>
<tr>
<td>25393</td>
<td>lengthening with autograft</td>
</tr>
<tr>
<td>25394</td>
<td>Osteoplasty, carpal bone, shortening</td>
</tr>
<tr>
<td>25400</td>
<td>Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)</td>
</tr>
<tr>
<td>25405</td>
<td>with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>25415</td>
<td>Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)</td>
</tr>
<tr>
<td>25420</td>
<td>with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>25425</td>
<td>Repair of defect with autograft; radius OR ulna</td>
</tr>
<tr>
<td>25426</td>
<td>radius AND ulna</td>
</tr>
<tr>
<td>25430</td>
<td>Insertion of vascular pedicle into carpal bone (eg, Hori procedure)</td>
</tr>
<tr>
<td>25431</td>
<td>Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone</td>
</tr>
<tr>
<td>25440</td>
<td>Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)</td>
</tr>
<tr>
<td>25441</td>
<td>Arthroplasty with prosthetic replacement; distal radius</td>
</tr>
<tr>
<td>25442</td>
<td>distal ulna</td>
</tr>
<tr>
<td>25443</td>
<td>scaphoid carpal (navicular)</td>
</tr>
<tr>
<td>25444</td>
<td>lunate</td>
</tr>
<tr>
<td>25445</td>
<td>trapezium</td>
</tr>
<tr>
<td>25446</td>
<td>distal radius and partial or entire carpus (&quot;total wrist&quot;)</td>
</tr>
<tr>
<td>25447</td>
<td>Arthroplasty interposition, intercarpal or carpometacarpal joints</td>
</tr>
<tr>
<td>25449</td>
<td>Revision of arthroplasty, including removal of implant, wrist joint</td>
</tr>
<tr>
<td>25450</td>
<td>Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna</td>
</tr>
<tr>
<td>25455</td>
<td>distal radius AND ulna</td>
</tr>
<tr>
<td>25490</td>
<td>Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius</td>
</tr>
<tr>
<td>25491</td>
<td>ulna</td>
</tr>
<tr>
<td>25492</td>
<td>radius AND ulna</td>
</tr>
</tbody>
</table>

**FRACTURE AND/OR DISLOCATION**

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

**ARTHRODESIS**

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

**AMPUTATION**

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

**OTHER PROCEDURES**

25999  Unlisted procedure, forearm or wrist

**HAND AND FINGERS**

**INCISION**

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

**EXCISION**

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

INTRODUCTION OR REMOVAL

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

26340  Manipulation, finger joint, under anesthesia, each joint
26341  Manipulation, palmar fascial cord (ie, Dupuytren’s cord), post enzyme injection (eg, collagenase), single cord
26350  Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon
26352  secondary with free graft (includes obtaining graft), each tendon
26356  Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon
26357  secondary, without free graft, each tendon
26358  secondary with free graft (includes obtaining graft), each tendon
26370  Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon
26372  secondary with free graft (includes obtaining graft), each tendon
26373  secondary without free graft, each tendon
26390  Excision flexor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod
26392  Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod
26410  Repair, extensor tendon, primary or secondary; without free graft, each tendon
26412  with free graft (includes obtaining graft), each tendon
26415  Excision of extensor tendon, implantation of synthetic rod for delayed tendon graft, hand or finger, each rod
26416  Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod
26418  Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon
26420  with free graft (includes obtaining each tendon graft)
26426  Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); using local tissue(s), including lateral band(s), each finger
26428  with free graft (includes obtaining graft), each finger
26432  Closed treatment of distal extensor tendon insertion, with or without percutaneous pinning (eg, mallet finger)
26433  Repair extensor tendon, distal insertion, primary or secondary; without graft (eg, mallet finger)
26434  with free graft (includes obtaining graft)
26437  Realignment of extensor tendon, hand, each tendon
26440  Tenolysis, flexor tendon; palm OR finger, each tendon
26442  palm AND finger, each tendon
26445  Tenolysis, extensor tendon, hand or finger; each tendon
26449  Tenolysis, complex, extensor tendon, finger, including forearm, each tendon
26450  Tenotomy, flexor, palm, open, each tendon
26455  Tenotomy, flexor, finger, open, each tendon
26460  Tenotomy, extensor, hand or finger, open, each tendon
26471  Tenodesis; of proximal interphalangeal joint, each joint
26474  of distal joint, each joint
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>26476</td>
<td>Lengthening of tendon, extensor, hand or finger, each tendon</td>
</tr>
<tr>
<td>26477</td>
<td>Shortening of tendon, extensor, hand or finger, each tendon</td>
</tr>
<tr>
<td>26478</td>
<td>Lengthening of tendon, flexor, hand or finger, each tendon</td>
</tr>
<tr>
<td>26479</td>
<td>Shortening of tendon, flexor, hand or finger, each tendon</td>
</tr>
<tr>
<td>26480</td>
<td>Transfer or transplant of tendon, carpometacarpal area or dorsum of hand, without free graft, each tendon</td>
</tr>
<tr>
<td>26483</td>
<td>with free tendon graft (includes obtaining graft), each tendon</td>
</tr>
<tr>
<td>26485</td>
<td>Transfer or transplant of tendon, palmar; without free tendon graft, each tendon</td>
</tr>
<tr>
<td>26489</td>
<td>with free tendon graft (includes obtaining graft), each tendon</td>
</tr>
<tr>
<td>26490</td>
<td>Opponensplasty; superficialis tendon transfer type, each tendon</td>
</tr>
<tr>
<td>26491</td>
<td>tendon transfer with graft (includes obtaining graft), each tendon</td>
</tr>
<tr>
<td>26494</td>
<td>hypothenar muscle transfer</td>
</tr>
<tr>
<td>26496</td>
<td>other methods</td>
</tr>
<tr>
<td>26497</td>
<td>Transfer of tendon to restore intrinsic function; ring and small finger</td>
</tr>
<tr>
<td>26498</td>
<td>all four fingers</td>
</tr>
<tr>
<td>26499</td>
<td>Correction claw finger, other methods</td>
</tr>
<tr>
<td>26500</td>
<td>Reconstruction of tendon pulley, each tendon; with local tissues (separate procedure)</td>
</tr>
<tr>
<td>26502</td>
<td>with tendon or fascial graft (includes obtaining graft) (separate procedure)</td>
</tr>
<tr>
<td>26508</td>
<td>Release of thenar muscle(s) (eg, thumb contracture)</td>
</tr>
<tr>
<td>26510</td>
<td>Cross intrinsic transfer, each tendon</td>
</tr>
<tr>
<td>26516</td>
<td>Capsulodesis, metacarpophalangeal joint; single digit</td>
</tr>
<tr>
<td>26517</td>
<td>two digits</td>
</tr>
<tr>
<td>26518</td>
<td>three or four digits</td>
</tr>
<tr>
<td>26520</td>
<td>Capsulectomy or capsulotomy; metacarpophalangeal joint, each joint</td>
</tr>
<tr>
<td>26525</td>
<td>interphalangeal joint, each joint</td>
</tr>
<tr>
<td>26530</td>
<td>Arthroplasty, metacarpophalangeal joint; each joint</td>
</tr>
<tr>
<td>26531</td>
<td>with prosthetic implant, each joint</td>
</tr>
<tr>
<td>26535</td>
<td>Arthroplasty interphalangeal joint; each joint</td>
</tr>
<tr>
<td>26536</td>
<td>with prosthetic implant, each joint</td>
</tr>
<tr>
<td>26540</td>
<td>Repair of collateral ligament, metacarpophalangeal or interphalangeal joint</td>
</tr>
<tr>
<td>26541</td>
<td>Reconstruction, collateral ligament, metacarpophalangeal joint, single, with tendon or fascial graft (includes obtaining graft)</td>
</tr>
<tr>
<td>26542</td>
<td>with local tissue (eg, adductor advancement)</td>
</tr>
<tr>
<td>26545</td>
<td>Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint</td>
</tr>
<tr>
<td>26546</td>
<td>Repair non-union, metacarpal or phalanx, (includes obtaining bone graft with or without external or internal fixation)</td>
</tr>
<tr>
<td>26548</td>
<td>Repair and reconstruction, finger, volar plate, interphalangeal joint</td>
</tr>
<tr>
<td>26550</td>
<td>Pollicization of a digit</td>
</tr>
<tr>
<td>26551</td>
<td>Transfer, toe-to-hand with microvascular anastomosis; great toe wrap around with bone graft</td>
</tr>
<tr>
<td>26553</td>
<td>other than great toe, single</td>
</tr>
<tr>
<td>26554</td>
<td>other than great toe, double</td>
</tr>
<tr>
<td>26555</td>
<td>Transfer, finger to another position without microvascular anastomosis</td>
</tr>
<tr>
<td>26556</td>
<td>Transfer, free toe joint, with microvascular anastomosis</td>
</tr>
<tr>
<td>26560</td>
<td>Repair of syndactyly (web finger), each web space; with skin flaps</td>
</tr>
<tr>
<td>26561</td>
<td>with skin flaps and grafts</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>26562</td>
<td>complex (eg, involving bone, nails)</td>
</tr>
<tr>
<td>26565</td>
<td>Osteotomy; metacarpal, each</td>
</tr>
<tr>
<td>26567</td>
<td>phalanx of finger, each</td>
</tr>
<tr>
<td>26568</td>
<td>Osteoplasty, lengthening, metacarpal or phalanx</td>
</tr>
<tr>
<td>26580</td>
<td>Repair cleft hand</td>
</tr>
<tr>
<td>26587</td>
<td>Reconstruction of polydactylous digit, soft tissue and bone</td>
</tr>
<tr>
<td>26590</td>
<td>Repair macrodactylia, each digit</td>
</tr>
<tr>
<td>26591</td>
<td>Repair, intrinsic muscles of hand, each muscle</td>
</tr>
<tr>
<td>26593</td>
<td>Release, intrinsic muscles of hand, each muscle</td>
</tr>
<tr>
<td>26596</td>
<td>Excision of constricting ring of finger, with multiple Z-plasties</td>
</tr>
</tbody>
</table>

**FRACTURE AND/OR DISLOCATION**

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

**ARTHRODESIS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>26820</td>
<td>Fusion in opposition, thumb, with autogenous graft (includes obtaining graft)</td>
</tr>
<tr>
<td>26841</td>
<td>Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation;</td>
</tr>
<tr>
<td>26842</td>
<td>with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>26843</td>
<td>Arthrodesis, carpometacarpal joint, digit, other than thumb, each;</td>
</tr>
<tr>
<td>26844</td>
<td>with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>26850</td>
<td>Arthrodesis, metacarpophalangeal joint, with or without internal fixation;</td>
</tr>
<tr>
<td>26852</td>
<td>with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>26860</td>
<td>Arthrodesis, interphalangeal joint, with or without internal fixation;</td>
</tr>
</tbody>
</table>
| 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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>26910</td>
<td>Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseous transfer</td>
</tr>
<tr>
<td>26951</td>
<td>Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure</td>
</tr>
<tr>
<td>26952</td>
<td>with local advancement flap (V-Y, hood)</td>
</tr>
</tbody>
</table>

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

**PELVIS AND HIP JOINT**

Including head and neck of femur.

**INCISION**

26990  Incision and drainage; pelvis or hip joint area; deep abscess or hematoma
26991  Incision and drainage; pelvis or hip joint area; 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  Biopsy, soft tissues of pelvis and hip area; deep subfascial or intramuscular
27043  Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater
27045  Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or
       greater
27047  Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm
27048  Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5
       cm
27049  Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm
27050  Arthrotomy, with biopsy; sacroiliac joint
27052  Arthrotomy, with biopsy; hip joint
27054  Arthrotomy with synovectomy, hip joint
27057  Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-
       minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of
       nonviable muscle, unilateral
       (To report bilateral procedure, use modifier -50)
27059  Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater
27060  Excision; ischial bursa
27062  trochanteric bursa or calcification
27065  Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; superficial, includes autograft, when performed
27066  deep (subfascial), includes autograft, when performed
27067  with autograft requiring separate incision
27070  Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial
27071  deep (subfascial or intramuscular)
27075  Radical resection of tumor or infection; wing of ilium, 1 pubic or ischial ramus or symphysis pubis
27076  ilium, including acetabulum, both pubic rami, or ischium and acetabulum
27077  innominate bone, total
27078  ischial tuberosity and greater trochanter of femur
27080  Coccygectomy, primary

**INTRODUCTION OR REMOVAL**

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

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

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

FRACTURE AND/OR DISLOCATION

27197 Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) or the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation
27198 with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)
27200 Closed treatment of coccygeal fracture
27202 Open treatment of coccygeal fracture
27215 Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, (eg, pelvic fracture(s) which do not disrupt the pelvic ring), with internal fixation
27216 Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)
27217 Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes pubic symphysis and/or ipsilateral superior/inferior rami)

27218 Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum)

(To report bilateral procedure, report 27215, 27216, 27217, 27218 with modifier -50)

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

27222 with manipulation, with or without skeletal traction

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

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

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

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

27232 with manipulation, with or without skeletal traction

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

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

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

27240 with manipulation, with or without skin or skeletal traction

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

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

27246 Closed treatment of greater trochanteric fracture, without manipulation

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

27250 Closed treatment of hip dislocation, traumatic; without anesthesia

27252 requiring anesthesia

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

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

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

27257 with manipulation, requiring anesthesia

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

27259

27265 Closed treatment of post hip arthroplasty dislocation; without anesthesia

27266 requiring regional or general anesthesia

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

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

**MANIPULATION**

27275  Manipulation, hip joint, requiring general anesthesia

**ARTHRODESIS**

27279  Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device

27280  Arthrodesis, open, sacroiliac joint, (including obtaining bone graft), including instrumentation, when performed

(To report bilateral procedures, use modifier -50)

27282  Arthrodesis, symphysis pubis (including obtaining graft)

27284  Arthrodesis, hip joint (includes obtaining graft);

27286  with subtrochanteric osteotomy

**AMPUTATION**

27290  Interpelviabdominal amputation (hind quarter amputation)

27295  Disarticulation of hip

**OTHER PROCEDURES**

27299  Unlisted procedure, pelvis or hip joint

**FEMUR (THIGH REGION) AND KNEE JOINT**

Including tibial plateaus.

**INCISION**

27301  Incision and drainage of deep abscess, bursa, or hematoma, thigh or knee region

27303  Incision, deep with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess)

27305  Fasciotomy, iliotibial (tenotomy), open

27306  Tenotomy, percutaneous, adductor or hamstring, single tendon (separate procedure)

27307  multiple tendons

27310  Arthrotomy, knee, with exploration, drainage or removal of foreign body (eg, infection)

**EXCISION**

27323  Biopsy, soft tissue of thigh or knee area; superficial

27324  deep (subfascial or intramuscular)

27325  Neurectomy, hamstring muscle

27326  Neurectomy, popliteal (gastrocnemius)

27327  Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm
27328  Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm
27329  Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm
     (see 27364 for 5 cm or greater)
27330  Arthrotomy, knee; with synovial biopsy only
27331   including joint exploration, biopsy, or removal of loose or foreign bodies
27332  Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral
27333   medial AND lateral
27334  Arthrotomy, with synovectomy; knee, anterior OR posterior
27335   anterior AND posterior including popliteal area
27337  Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater
27339  Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or
greater
27340  Excision, prepatellar bursa
27345  Excision of synovial cyst of popliteal space (eg, Baker's cyst)
27347  Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee
27350  Patelllectomy or hemipatelllectomy
27355  Excision or curettage of bone cyst or benign tumor of femur;
     with allograft
27356   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

27370  Injection of contrast for knee arthrography
     (For radiological supervision and interpretation, use 73580. Do not report 77002 in
     conjunction with 73580)
27372  Removal foreign body, deep, thigh region or knee area

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
27407  collateral and cruciate ligaments
27415  Osteochondral allograft, knee, open
27416  Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])
(Do not report 27416 in conjunction with 27415, 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)
27418  Anterior tibial tubercleplasty (eg, Maquet type procedure)
27420  Reconstruction of dislocating patella; (eg, Hauser type procedure)
27422  with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)
27424  with patellectomy
27425  Lateral retinacular release open
27427  Ligamentous reconstruction (augmentation), knee; extra-articular
27428  intra-articular (open)
27429  intra-articular (open) and extra-articular
27430  Quadricepsplasty (eg, Bennett or Thompson type)
27435  Capsulotomy, posterior release, knee
27437  Arthroplasty, patella; without prosthesis
27438  with prosthesis
27440  Arthroplasty, knee, tibial plateau;
27441  with debridement and partial synovectomy
27442  Arthroplasty, femoral condyles or tibial plateau(s), knee;
27443  with debridement and partial synovectomy
27445  Arthroplasty, knee, hinge prosthesis (eg, Walldius type)
27446  Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
27447  medial AND lateral compartments with or without patella resurfacing (total knee replacement)
27448  Osteotomy, femur, shaft or supracondylar; without fixation
27450  with fixation
27454  Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft, (eg, Sofield type procedure)
27455  Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)); before epiphyseal closure
27457  after epiphyseal closure
(To report 27448-27450, 27455-27457 as bilateral procedures, use modifier -50)
27465  Osteoplasty, femur; shortening (excluding 64876)
27466  lengthening
27468  combined, lengthening and shortening with femoral segment transfer
27470  Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)
27472  with iliac or other autogenous bone graft (includes obtaining graft)
27475  Arrest, epiphyseal, any method (eg, epiphysiodesis); distal femur
27477  tibia and fibula, proximal
27479  combined distal femur, proximal tibia and fibula
27485  Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, for genu varus or valgus)
27486  Revision of total knee arthroplasty, with or without allograft; one component
27487  femoral and entire tibial component
27488  Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee
27495  Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femur
27496  Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);
27497  with debridement of nonviable muscle and/or nerve
27498  Decompression fasciotomy, thigh and/or knee, multiple compartments;
27499  with debridement of nonviable muscle and/or nerve

FRACTURE AND/OR DISLOCATION

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

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

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

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

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

INCISION

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

EXCISION

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

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

REPAIR, REVISION, AND/OR RECONSTRUCTION

27650 Repair, primary, open or percutaneous ruptured Achilles tendon;
27652      with graft (includes obtaining graft)
27654 Repair, secondary, ruptured Achilles tendon, with or without graft
27656 Repair, fascial defect of leg
27658 Repair or suture of flexor tendon, leg; primary, without graft, each tendon
27659      secondary with or without graft, each tendon
27664 Repair, extensor tendon, leg; primary, without graft, each tendon
27665      secondary with or without graft, each tendon
27675 Repair dislocating peroneal tendons; without fibular osteotomy
27676      with fibular osteotomy
27680 Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon
27681      multiple tendons (through same incision(s))
27685 Lengthening or shortening of tendon; leg or ankle; single tendon (separate procedure)
27686      multiple tendons (through same incision), each
27687 Gastrocnemius recession (eg, Strayer procedure)
27690 Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)
27691      deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)
27692      each additional tendon
           (List separately in addition to primary procedure)
           (Use 27692 in conjunction with 27690, 27691)
27695 Repair, primary, disrupted ligament, ankle; collateral
27696      both collateral ligaments
27698 Repair, secondary disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)
27700 Arthroplasty, ankle;
27702      with implant (total ankle)
27703      revision, total ankle
27704 Removal of ankle implant
27705 Osteotomy; tibia
27707      fibula
27709      tibia and fibula
27712      multiple, with realignment on intramedullary rod (eg, Sofield type procedure)
27715 Osteoplasty, tibia and fibula, lengthening or shortening
27720 Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)
27722      with sliding graft
27724      with iliac or other autograft (includes obtaining graft)
27725      by synostosis, with fibula, any method
27726      repair of fibula nonunion and/or malunion with internal fixation
           (Do not report 27726 in conjunction with 27707)
27727 Repair of congenital pseudarthrosis, tibia
27730 Arrest, epiphyseal (epiphysiodesis), open; distal tibia
distal fibula
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
with manipulation, with or without skeletal traction
27752 Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture) (eg, pins or screws)
27756 Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with
or without cerclage
27758 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
with manipulation, with or without skin or skeletal traction
27762 Open treatment of medial malleolus fracture, includes internal fixation, when performed
27764 Closed treatment of posterior malleolus fracture; without manipulation
with manipulation
27766 Open treatment of posterior malleolus fracture, includes internal fixation, when performed
(Do not report 27767-27769 in conjunction with 27808-27823)
27768 Closed treatment of proximal fibula or shaft fracture; without manipulation
with manipulation
27770 Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed
27772 Closed treatment of distal fibular fracture (lateral malleolus); without manipulation
with manipulation
27774 Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed
27776 Closed treatment of bimalleolar ankle fracture, (eg, lateral and medial malleoli, or lateral and
posterior malleoli or medial and posterior malleoli); without manipulation
with manipulation
27778 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
27780 Closed treatment of trimalleolar ankle fracture; without manipulation
with manipulation
27782 Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed,
medial and/or lateral malleolus; without fixation of posterior lip
with fixation of posterior lip
27824 Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation
27825 with skeletal traction and/or requiring manipulation
27826 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation; when performed; of fibula only
27827 of tibia only
27828 of both tibia and fibula
27829 Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed
27830 Closed treatment of proximal tibiofibular joint dislocation; without anesthesia
27831 requiring anesthesia
27832 Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula
27840 Closed treatment of ankle dislocation; without anesthesia
27842 requiring anesthesia, with or without percutaneous skeletal fixation
27846 Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation
27848 with repair or internal or external fixation

MANIPULATION

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

ARTHRODESIS

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

AMPUTATION

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

OTHER PROCEDURES

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

**FOOT AND TOES**

**INCISION**

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

**EXCISION**

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

INTRODUCTION OR REMOVAL

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

REPAIR, REVISION, AND/OR RECONSTRUCTION

28200  Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon
28202  secondary with free graft, each tendon (includes obtaining graft)
28208  Repair, tendon, extensor, foot; primary or secondary, each tendon
28210  secondary with free graft, each tendon (includes obtaining graft)
28220  Tenolysis, flexor, foot; single tendon
28222  multiple tendons
28225  Tenolysis, extensor, foot; single tendon
28226  multiple tendons
28230  Tenotomy, open, tendon flexor; foot, single or multiple tendon(s) (separate procedure)
28232  toe, single tendon (separate procedure)
28234 Tenotomy, open, extensor, foot or toe, each tendon
28238 Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)
28240 Tenotomy lengthening, or release, abductor hallucis muscle
28250 Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure)
28260 Capsulotomy, midfoot; medial release only (separate procedure)
28261 with tendon lengthening
28262 extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)
28264 Capsulotomy, midtarsal (eg, Heyman type procedure)
28270 Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)
28272 interphalangeal joint, each joint (separate procedure)
28280 Syndactylization, toes (eg, webbing or Kelikian type procedure)
28285 Correction, hammertoe; (eg, interphalangeal fusion, partial or total phalangectomy)
28286 Correction, cock-up fifth toe, with plastic skin closure (Ruiz-Mora type procedure)
28288 Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head
28289 Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant
28291 with implant
28292 Correction, hallux valgus (bunionectomy), with sesamoidectomy when performed; with resection of proximal phalanx base, when performed, any method
28296 with distal metatarsal osteotomy, any method
28295 with proximal metatarsal osteotomy, any method
28297 with first metatarsal and medical cuneiform joint arthrodesis, any method
28298 with proximal phalanx osteotomy, any method
28299 with double osteotomy, any method
28300 Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation
28302 talus
28304 Osteotomy, tarsal bones, other than calcaneus or talus;
28305 with autograft (includes obtaining graft) (eg, Fowler type)
28306 Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal
28307 first metatarsal with autograft (other than first toe)
28308 other than first metatarsal, each
28309 multiple, (eg, Swanson type cavus foot procedure)
28310 Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
28312 other phalanges, any toe
28313 Reconstruction, angular deformity of toe, soft tissue procedures only (overlapping second toe, fifth toe, curly toes)
28315 Sesamoidectomy, first toe (separate procedure)
28320 Repair of nonunion or malunion; tarsal bones
28322 metatarsal, with or without bone graft (includes obtaining graft)
28340 Reconstruction, toe, macrodactyly; soft tissue resection
28341 requiring bone resection
28344 Reconstruction, toe(s); polydactyly
28345 syndactyly, with or without skin graft(s), each web
28360 Reconstruction, cleft foot

FRACTURE AND/OR DISLOCATION

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

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

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

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

(Separate Procedure Only)

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

BODY AND UPPER EXTREMITY

CASTS

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

SPLINTS

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

LOWER EXTREMITY

CASTS

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

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

STRAPPING-ANY AGE

29580 Strapping; Unna boot
29581 Application of multi-layer compression system; leg (below knee), including ankle and foot
29582 thigh and leg, including ankle and foot, when performed
29583 upper arm and forearm
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); unicortyl, 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

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29873  with lateral release
29874  for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)
29875  synovectomy, limited (eg, plica or shelf resection) (separate procedure)
29876  synovectomy, major, two or more compartments (eg, medial or lateral)
29877  debridement/shaving of articular cartilage (chondroplasty)
29879  abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
29880  with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29881  with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29882  with meniscus repair (medial or lateral)
29883  with meniscus repair (medial and lateral)
29884  with lysis of adhesions with or without manipulation (separate procedure)
29885  drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)
29886  drilling for intact osteochondritis dissecans lesion
29887  drilling for intact osteochondritis dissecans lesion with internal fixation
29888  Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29889  Arthroscopically aided posterior cruciate ligament repair/ augmentation or reconstruction (Procedures 29888 and 29889 should not be used with reconstruction procedures 27427-27429)
29891  Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and/or tibia, including drilling of the defect
29892  Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)
29893  Endoscopic plantar fasciotomy
29894  Arthroscopy ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body
29895  synovectomy, partial
29897  debridement, limited
29898  debridement, extensive
29899  with ankle arthrodesis
29900  Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy (Do not report 29900 with 29901, 29902)
29901  Arthroscopy, metacarpophalangeal joint, surgical; with debridement
29902  with reduction of displaced ulnar collateral ligament (eg, Stenar Lesion)
29904  Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body
29905  Arthroscopy, subtalar joint, surgical; with synovectomy
29906  Arthroscopy, subtalar joint, surgical; with debridement
29907  Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis
29914  Arthroscopy, hip, surgical; with removal of loose body or foreign body with femoroplasty (ie., treatment of cam lesion)
29915       with acetabuloplasty (ie, treatment of pincer lesion)
            (Do not report 29914, 29915 in conjunction with 29862, 29863)
29916       with labral repair
            (Do not report 29916 for labral repair secondary to acetabuloplasty or in conjunction with 29862, 29863)
29999  Unlisted procedure, arthroscopy

RESPIRATORY SYSTEM

NOSE

INCISION

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

EXCISION

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

INTRODUCTION

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

REMOVAL OF FOREIGN BODY

30300  Removal foreign body, intranasal; office type procedure
30310       requiring general anesthesia
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30320</td>
<td>by lateral rhinotomy</td>
</tr>
<tr>
<td>30400</td>
<td>Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip</td>
</tr>
<tr>
<td>30410</td>
<td>complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip</td>
</tr>
<tr>
<td>30420</td>
<td>including major septal repair</td>
</tr>
<tr>
<td>30430</td>
<td>Rhinoplasty, secondary; minor revision (small amount of nasal tip work)</td>
</tr>
<tr>
<td>30435</td>
<td>intermediate revision (bony work with osteotomies)</td>
</tr>
<tr>
<td>30450</td>
<td>major revision (nasal tip work and osteotomies)</td>
</tr>
<tr>
<td>30460</td>
<td>Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only</td>
</tr>
<tr>
<td>30462</td>
<td>tip, septum, osteotomies</td>
</tr>
<tr>
<td>30465</td>
<td>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)</td>
</tr>
<tr>
<td>30520</td>
<td>Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft</td>
</tr>
<tr>
<td>30540</td>
<td>Repair choanal atresia; intranasal</td>
</tr>
<tr>
<td>30545</td>
<td>transpalatine</td>
</tr>
<tr>
<td>30546</td>
<td>(Do not report modifier –63 in conjunction with 30540, 30545)</td>
</tr>
<tr>
<td>30560</td>
<td>Lysis intranasal synechia</td>
</tr>
<tr>
<td>30580</td>
<td>Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)</td>
</tr>
<tr>
<td>30600</td>
<td>oronasal</td>
</tr>
<tr>
<td>30620</td>
<td>Septal or other intranasal dermatoplasty (does not include obtaining graft)</td>
</tr>
<tr>
<td>30630</td>
<td>Repair nasal septal perforations</td>
</tr>
<tr>
<td>30801</td>
<td>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)</td>
</tr>
<tr>
<td>30802</td>
<td>intramural; (ie, submucosal)</td>
</tr>
<tr>
<td></td>
<td>(Do not report 30801, 30802, 30930 in conjunction with 30130 or 30140)</td>
</tr>
<tr>
<td>30901</td>
<td>Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method (To report bilateral procedure, use modifier -50)</td>
</tr>
<tr>
<td>30903</td>
<td>Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method (To report bilateral procedure, use modifier -50)</td>
</tr>
<tr>
<td>30905</td>
<td>Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial</td>
</tr>
<tr>
<td>30906</td>
<td>subsequent</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>30915</td>
<td>Ligation arteries; ethmoidal</td>
</tr>
<tr>
<td>30920</td>
<td>internal maxillary artery, transantral</td>
</tr>
<tr>
<td>30930</td>
<td>Fracture nasal inferior turbinate(s), therapeutic</td>
</tr>
<tr>
<td></td>
<td>(Do not report 30801, 30802, 30930 in conjunction with 30130 or 30140)</td>
</tr>
<tr>
<td>30999</td>
<td>Unlisted procedure, nose</td>
</tr>
</tbody>
</table>

**LARYNX**

**EXCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31300</td>
<td>Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectomy</td>
</tr>
<tr>
<td>31320</td>
<td>diagnostic</td>
</tr>
<tr>
<td>31360</td>
<td>Laryngectomy; total, without radical neck dissection</td>
</tr>
<tr>
<td>31365</td>
<td>total, with radical neck dissection</td>
</tr>
<tr>
<td>31367</td>
<td>subtotal supraglottic, without radical neck dissection</td>
</tr>
<tr>
<td>31368</td>
<td>subtotal supraglottic, with radical neck dissection</td>
</tr>
<tr>
<td>31370</td>
<td>Partial laryngectomy (hemilaryngectomy); horizontal</td>
</tr>
<tr>
<td>31375</td>
<td>laterovertical</td>
</tr>
<tr>
<td>31380</td>
<td>anterovertical</td>
</tr>
<tr>
<td>31382</td>
<td>antero-latero-vertical</td>
</tr>
<tr>
<td>31390</td>
<td>Pharyngolaryngectomy, with radical neck dissection; without reconstruction</td>
</tr>
<tr>
<td>31395</td>
<td>with reconstruction</td>
</tr>
<tr>
<td>31400</td>
<td>Arytenoidectomy or arytenoidopexy, external approach</td>
</tr>
<tr>
<td>31420</td>
<td>Epiglottidectomy</td>
</tr>
</tbody>
</table>

**INTRODUCTION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31500</td>
<td>Intubation, endotracheal, emergency procedure</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31505</td>
<td>Laryngoscopy, indirect; diagnostic (separate procedure)</td>
</tr>
<tr>
<td>31510</td>
<td>with biopsy</td>
</tr>
<tr>
<td>31511</td>
<td>with removal of foreign body</td>
</tr>
<tr>
<td>31512</td>
<td>with removal of lesion</td>
</tr>
<tr>
<td>31513</td>
<td>with vocal cord injection</td>
</tr>
<tr>
<td>31515</td>
<td>Laryngoscopy, direct, with or without tracheoscopy; for aspiration</td>
</tr>
<tr>
<td>31520</td>
<td>diagnostic, newborn</td>
</tr>
<tr>
<td></td>
<td>(Do not report 31520 with modifier –63)</td>
</tr>
<tr>
<td>31525</td>
<td>diagnostic, except newborn</td>
</tr>
<tr>
<td>31526</td>
<td>diagnostic, with operating microscope or telescope</td>
</tr>
<tr>
<td>31527</td>
<td>with insertion of obturator</td>
</tr>
<tr>
<td>31528</td>
<td>with dilation, initial</td>
</tr>
<tr>
<td>31529</td>
<td>with dilation, subsequent</td>
</tr>
<tr>
<td>31530</td>
<td>Laryngoscopy, direct, operative, with foreign body removal;</td>
</tr>
</tbody>
</table>
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)
31540  Laryngoscopy, direct, operative, with arytenoidectomy;
31541  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
31595  Section recurrent laryngeal nerve, therapeutic (separate procedure), unilateral
OTHER PROCEDURES

31599 Unlisted procedure, larynx

TRACHEA AND BRONCHI

INCISION

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

ENDOSCOPY

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

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

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

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

OTHER PROCEDURES
31899 Unlisted procedure, trachea, bronchi

LUNGS AND PLEURA

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

**EXCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>32310</td>
<td>Pleurectomy; parietal (separate procedure)</td>
</tr>
<tr>
<td>32320</td>
<td>Decortication and parietal pleurectomy</td>
</tr>
<tr>
<td>32400</td>
<td>Biopsy, pleura; percutaneous needle</td>
</tr>
<tr>
<td>32405</td>
<td>Biopsy, lung or mediastinum, percutaneous needle</td>
</tr>
</tbody>
</table>

**REMOVAL**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>32440</td>
<td>Removal of lung, pneumonectomy;</td>
</tr>
<tr>
<td>32442</td>
<td>with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)</td>
</tr>
<tr>
<td>32445</td>
<td>extrapleural</td>
</tr>
<tr>
<td>32480</td>
<td>Removal of lung, other than pneumonectomy; single lobe (lobectomy)</td>
</tr>
<tr>
<td>32482</td>
<td>2 lobes (bilobectomy)</td>
</tr>
<tr>
<td>32484</td>
<td>single segment (segmentectomy)</td>
</tr>
<tr>
<td>32486</td>
<td>with circumferential resection of segment of bronchus followed by broncho bronchial-anastomosis (sleeve lobectomy)</td>
</tr>
<tr>
<td>32488</td>
<td>with all remaining lung following previous removal of a portion of lung (completion pneumonectomy)</td>
</tr>
<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>
</tr>
<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) (Use 32501 in conjunction with codes 32480, 32482, 32484) (32501 is to be used when a portion of the bronchus to preserved lung is removed and requires plastic closure to preserve function of that preserved lung. It is not to be used for closure for the proximal end of a resected bronchus)</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>
</tbody>
</table>
32507 with diagnostic wedge resection followed by anatomic lung resection
   (List separately in addition to primary procedure)
   (Report 32507 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504)

32540 Extrapleural enucleation of empyema (empyemectomy);

INTRODUCTION AND REMOVAL

32550 Insertion of indwelling tunneled pleural catheter with cuff
   (Do not report 32550 in conjunction with 32554, 32555)

32551 Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)
   (Do not report 32551 in conjunction with 19260, 19271, 19272, 32503, 32504)

32552 Removal of indwelling tunneled pleural catheter with cuff

32553 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple
   (Report supply of device separately)

32554 Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance

32555 with imaging guidance

32556 Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance

32557 with imaging guidance

DESTRUCTION

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

32561 Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day

32562 subsequent day

ENDOSCOPY

Surgical thoracoscopy always includes diagnostic thoracoscopy.

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

32601 Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without biopsy

32604 pericardial sac, with biopsy

32606 mediastinal space, with biopsy

32607 Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
   (Do not report 32607 in conjunction with 32440, 32442, 32445, 32488, 32671)

32608 with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
   (Do not report 32608 in conjunction with 32440, 32442, 32445, 32488, 32671)

32609 with biopsy(ies) of pleura

32650 Thoracoscopy, surgical; with pleurodesis, (eg, mechanical or chemical)
32651 with partial pulmonary decortication
32652 with total pulmonary decortication, including intrapleural pneumonolysis
32653 with removal of intrapleural foreign body or fibrin deposit
32654 with control of traumatic hemorrhage
32655 with resection-plication of bullae, includes any pleural procedure when performed
32656 with parietal pleurectomy
32658 with removal of clot or foreign body from pericardial sac
32659 with creation of pericardial window or partial resection of pericardial sac for drainage
32661 with excision of pericardial cyst, tumor, or mass
32662 with excision of mediastinal cyst, tumor, or mass
32663 with lobectomy (single lobe)
32664 with thoracic sympathectomy
32665 with esophagectomy (Heller type)
32666 with therapeutic wedge resection (eg, mass, nodule), initial unilateral
   (To report bilateral procedure, report 32666 with modifier 50)
32667 with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral
   (List separately in addition to primary code)
   (Report 32667 only in conjunction with 32666)
   (Do not report 32666, 32667 in conjunction with 32440, 32442, 32445, 32488, 32671)
32668 with diagnostic wedge resection followed by anatomic lung resection
   (List separately in addition to primary code)
   (Report 32668 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32663, 32669, 32670, 32671)
32669 with removal of a single lung segment (segmentectomy)
32670 with removal of two lobes (bilobectomy)
32671 with removal of lung (pneumonectomy)
32672 with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed
32673 with resection of thymus, unilateral or bilateral
32674 with mediastinal and regional lymphadenectomy
   (List separately in addition to primary procedure)
   (Report 32674 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32505, 32663, 32666, 32667, 32669, 32670, 32671)

STEREOTACTIC RADIATION THERAPY

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

REPAIR

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

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

SURGICAL COLLAPSE THERAPY; THORACOPLASTY

32900 Resection of ribs, extrapleural, all stages
32905 Thoracoplasty, Schede type or extrapleural (all stages); 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 one or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral
32999 Unlisted procedure, lungs and pleura

ACCESSORY SINUSES

INCISION

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

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

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

ENDOSCOPY

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

31231 Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
31233 Nasal/sinus endoscopy, diagnostic; with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)
31235 with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)
31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)
31238 with control of nasal hemorrhage
31239 with dacryocystorhinostomy
31240 with concha bullosa resection
31254 Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)
31255 with ethmoidectomy, total (anterior and posterior)
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, with or without removal of tissue from frontal sinus
31287 Nasal/sinus endoscopy, surgical, with sphenoidotomy;
31288 with removal of tissue from sphenoid sinus
31290 Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region
31291 sphenoid region
31292 Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression
31293 with medial orbital wall and inferior orbital wall decompression
31294 with optic nerve decompression
31295 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa
(Do not report 31295 in conjunction with 31233, 31256, 31267 when performed on the same sinus)
31296 with dilation of frontal sinus ostium (eg, balloon dilation)
(Do not report 31296 in conjunction with 31276 when performed on the same sinus)
31297 with dilation of sphenoid sinus ostium (eg, balloon dilation)
(Do not report 31297 in conjunction with 31235, 31287, 31288 when performed on the same sinus)

OTHER PROCEDURES

31299 Unlisted procedure, accessory sinuses

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

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

CARDIAC TUMOR

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

TRANSMYOCARDIAL REVASCULARIZATION

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

PACEMAKER OR PACING CARDIOVERTER-DEFIBRILLATOR

A pacemaker system includes a pulse generator containing electronics and a battery, and one or more electrodes (leads). Pulse generators are placed in a subcutaneous "pocket" created in either a subclavicular or underneath the abdominal muscles just below the ribcage.
Electrodes may be inserted through a vein (transvenous) or they may be placed on the surface of the heart (epicardial). The epicardial location of electrodes requires a thoracotomy for electrode insertion.

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

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

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

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

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

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

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

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

**ELECTROPHYSIOLOGIC OPERATIVE PROCEDURES**

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

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

DEFINITIONS:

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

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

INCISION

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

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

PATIENT- ACTIVATED EVENT RECORDER

33282  Implantation of patient-activated cardiac event recorder
      (Initial implantation includes programming.)
33284  Removal of an implantable, patient-activated cardiac event recorder

WOUNDS OF THE HEART AND GREAT VESSELS

33300  Repair of cardiac wound; without bypass
33305  with cardiopulmonary bypass
33310  Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); without bypass
33315  with cardiopulmonary bypass
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)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>33404</td>
<td>Construction of apical-aortic conduit</td>
</tr>
<tr>
<td>33405</td>
<td>Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve</td>
</tr>
<tr>
<td>33406</td>
<td>with allograft valve (freehand)</td>
</tr>
<tr>
<td>33410</td>
<td>with stentless tissue valve</td>
</tr>
<tr>
<td>33411</td>
<td>Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus</td>
</tr>
<tr>
<td>33412</td>
<td>with transventricular aortic annulus enlargement (Konno procedure)</td>
</tr>
<tr>
<td>33413</td>
<td>by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)</td>
</tr>
<tr>
<td>33414</td>
<td>Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract</td>
</tr>
<tr>
<td>33415</td>
<td>Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis</td>
</tr>
<tr>
<td>33416</td>
<td>Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy)</td>
</tr>
<tr>
<td>33417</td>
<td>Aortoplasty (gusset) for supravalvular stenosis</td>
</tr>
</tbody>
</table>

### MITRAL VALVE

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

### TRICUSPID VALVE

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33460</td>
<td>Valvectomy, tricuspid valve, with cardiopulmonary bypass;</td>
</tr>
<tr>
<td>33463</td>
<td>Valvuloplasty, tricuspid valve; without ring insertion</td>
</tr>
<tr>
<td>33464</td>
<td>with ring insertion</td>
</tr>
<tr>
<td>33465</td>
<td>Replacement, tricuspid valve, with cardiopulmonary bypass</td>
</tr>
<tr>
<td>33468</td>
<td>Tricuspid valve repositioning and plication for Ebstein anomaly</td>
</tr>
</tbody>
</table>

### PULMONARY VALVE

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33470</td>
<td>Valvotomy, pulmonary valve, closed heart; transventricular</td>
</tr>
<tr>
<td>33471</td>
<td>via pulmonary artery</td>
</tr>
<tr>
<td>33474</td>
<td>Valvotomy, pulmonary valve, open heart, with cardiopulmonary bypass</td>
</tr>
<tr>
<td>33475</td>
<td>Replacement, pulmonary valve</td>
</tr>
</tbody>
</table>
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 arterio-cardiac 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
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 (e.g., 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 atroventricular 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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33610</td>
<td>Repair of complex cardiac anomalies (eg, single ventricle with subaortic obstruction) by surgical enlargement of ventricular septal defect</td>
</tr>
<tr>
<td>33611</td>
<td>Repair of double outlet right ventricle with intraventricular tunnel repair;</td>
</tr>
<tr>
<td>33612</td>
<td>with repair of right ventricular outflow tract obstruction</td>
</tr>
<tr>
<td>33615</td>
<td>Repair of complex cardiac anomalies (eg, tricuspid atresia) by closure of atrial septal defect and anastomosis of atri or vena cava to pulmonary artery (simple Fontan procedure)</td>
</tr>
<tr>
<td>33617</td>
<td>Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure</td>
</tr>
<tr>
<td>33619</td>
<td>Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)</td>
</tr>
<tr>
<td>33620</td>
<td>Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)</td>
</tr>
<tr>
<td>33621</td>
<td>Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)</td>
</tr>
<tr>
<td>33622</td>
<td>Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding) (Do not report 33622 in conjunction with 33619, 33767, 33822, 33840, 33845, 33851, 33853, 33917)</td>
</tr>
<tr>
<td>33641</td>
<td>Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch</td>
</tr>
<tr>
<td>33645</td>
<td>Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage</td>
</tr>
<tr>
<td>33647</td>
<td>Repair of atrial septal defect and ventricular septal defect, with direct or patch closure</td>
</tr>
<tr>
<td>33660</td>
<td>Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair</td>
</tr>
<tr>
<td>33665</td>
<td>Repair of intermediate or transitional atrioventricular canal, with or without atrioventricular valve repair</td>
</tr>
<tr>
<td>33670</td>
<td>Repair of complete atrioventricular canal, with or without prosthetic valve</td>
</tr>
<tr>
<td>33675</td>
<td>Closure of multiple ventricular septal defects;</td>
</tr>
<tr>
<td>33676</td>
<td>with pulmonary valvotomy or infundibular resection (acyanotic)</td>
</tr>
<tr>
<td>33677</td>
<td>with removal of pulmonary artery band, with or without gusset</td>
</tr>
<tr>
<td>33681</td>
<td>Closure of single ventricular septal defect, with or without patch;</td>
</tr>
<tr>
<td>33684</td>
<td>with pulmonary valvotomy or infundibular resection (acyanotic)</td>
</tr>
<tr>
<td>33688</td>
<td>with removal of pulmonary artery band, with or without gusset</td>
</tr>
<tr>
<td>33690</td>
<td>Banding of pulmonary artery</td>
</tr>
<tr>
<td>33692</td>
<td>Complete repair tetralogy of Fallot without pulmonary atresia;</td>
</tr>
<tr>
<td>33694</td>
<td>with transannular patch</td>
</tr>
<tr>
<td>33697</td>
<td>Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect</td>
</tr>
</tbody>
</table>

**SEPTAL DEFECT**

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

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

VENOUS ANOMALIES
(Do not report modifier –63 in conjunction with 33730, 33732)
33724 Repair of isolated partial anomalous pulmonary venous return (eg, scimitar syndrome)
33726 Repair of pulmonary venous stenosis
(Do not report 33724, 33726 in conjunction with 32551, 33210, 33211)
33730 Complete repair of anomalous venous return (supracardiac, intracardiac, or infracardiac types)
33732 Repair of cor triatriatum or supravalvular mitral ring by resection of left atrial membrane

SHUNTING PROCEDURES
(Do not report modifier –63 in conjunction with 33735, 33736, 33750, 33755, 33762)
33735 Atrial septectomy or septostomy; closed heart (Blalock-Hanlon type operation)
33736 open heart with cardiopulmonary bypass
33737 open heart, with inflow occlusion
33750 Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation)
33755 ascending aorta to pulmonary artery (Waterston type operation)
33762 descending aorta to pulmonary artery (Potts-Smith type operation)
33764 central, with prosthetic graft
33766 superior vena cava to pulmonary artery for flow to one lung (classical Glenn procedure)
33767 superior vena cava to pulmonary artery for flow to both lungs (bidirectional Glenn procedure)
33768 Anastomosis, cavopulmonary, second superior vena cava
(List separately in addition to primary procedure)

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

**TRUNCUS ARTERIOSUS**

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

**AORTIC ANOMALIES**

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

**THORACIC AORTIC ANEURYSM**

33860 Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed
33863 with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)
33864 with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)
33870 Transverse arch graft, with cardiopulmonary bypass
33875 Descending thoracic aorta graft, with or without bypass
33877 Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass

**ENDOVASCULAR REPAIR OF DESCENDING THORACIC AORTA**
Codes 33880-33891 represent a family of procedures to report placement of an endovascular graft for repair of the descending thoracic aorta. These codes include all device introduction, manipulation, positioning, and deployment. All balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment, are not separately reportable. Open arterial exposure and associated closure of the arteriotomy sites (eg, 34812, 34820, 34833, 34834), introduction of guidewires and catheters (eg, 36140, 36200-36218), and extensive repair or replacement of an artery (eg, 35226, 35286) should be additionally reported. Transposition of subclavian artery to carotid, and carotid-carotid bypass performed in conjunction with endovascular repair of the descending thoracic aorta (eg, 33889, 33891) should be separately reported. The primary codes, 33880 and 33881, include placement of all distal extensions, if required, in the distal thoracic aorta, while proximal extensions, if needed, are reported separately. For fluoroscopic guidance in conjunction with endovascular repair of the thoracic aorta, see codes 75956-75959 as appropriate. Codes 75956 and 75957 include all angiography of the thoracic aorta and its branches for diagnostic imaging prior to deployment of the primary endovascular devices (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff). Code 75958 includes the analogous services for placement of each proximal thoracic endovascular extension. Code 75959 includes the analogous services for placement of a distal thoracic endovascular extension(s) placed during a procedure after the primary repair.

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

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

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

HEART/LUNG TRANSPLANTATION

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,
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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 surgeon, as indicated. Sympathectomy, when done, is included in the listed aortic procedures. For unlisted vascular procedure, use 37799.

EMBOLECTOMY/THROMBECTOMY

ARTERIAL, WITH OR WITHOUT CATHETER

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

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

VENOUS RECONSTRUCTION

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

ENDOVASCULAR REPAIR OF ABDOMINAL AORTIC ANEURYSM

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

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

For fluoroscopic guidance in conjunction with endovascular aneurysm repair, see code 75952 or 75953, as appropriate.

Code 75952 includes angiography of the aorta and its branches for diagnostic imaging prior to deployment of the endovascular device (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff). Code 75953 includes the analogous services for placement of additional extension prostheses (not for routine components of modular devices).

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

34800  Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis
34802  using modular bifurcated prosthesis (one docking limb)
34803  using modular bifurcated prosthesis (two docking limbs)
34804  using unibody bifurcated prosthesis
34805  using aorto-uniiiliac or aorto-unifemoral prosthesis
34806  Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data
   (List separately in addition to primary procedure)
   (Do not report 34806 in conjunction with 93982)
   (Use 34806 in conjunction with 33880, 33881, 33886, 34800-34805, 34825, 34900)

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

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

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

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

34825  Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel
   each additional vessel
   (List separately in addition to primary procedure)
   (Use 34826 in conjunction with code 34825)
   (Use 34825, 34826 in addition to 34800-34805, 34900 as appropriate)

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

34831  aorto-bi-iliac prosthesis

34832  aorto-bifemoral prosthesis

34833  Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral
   (Do not report 34833 in addition to 34820)
   (For bilateral procedure, use modifier -50)

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

FENESTRATED ENDOVASCULAR REPAIR of the VISCERAL and INFRARENAL AORTA
Codes 34841-34844 and 34845-34848 define the total number of visceral and/or renal arteries (ie, celiac, superior mesenteric, and/or unilateral or bilateral renal artery(s)) requiring placement of an endoprosthesis (ie, bare metal or covered stent) through an aortic endograft fenestration.

Introduction of guide wires and catheters in the aorta and visceral and/or renal arteries is included in the work of 34841-34848 and is not separately reportable. Fluoroscopic guidance and radiological supervision and interpretation in conjunction with fenestrated endovascular aortic repair is not separately reportable and includes angiographic diagnostic imaging of the aorta and its branches prior to deployment of the fenestrated endovascular device, fluoroscopic guidance in the delivery of
the fenestrated endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) done at the time of the endovascular repair.

Other interventional procedures performed at the time of fenestrated endovascular abdominal aortic aneurysm repair may be reported separately (eg, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery(s) outside the endoprosthesis target zone when done before or after deployment of endoprosthesis).

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

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

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

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

34845 Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneuysm, dissection, penetrating ulcer, 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 endoprostheses (superior mesenteric, celiac or renal artery[s])

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

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

ENDOVASCULAR REPAIR OF ILIAC ANEURYSM

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

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

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

34900  Endovascular repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous 
malformation, trauma) using ilio-iliac tube endoprosthesis **(Report required)** 
(For bilateral procedure, use modifier 50)

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

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

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

35002  for ruptured aneurysm, carotid, subclavian artery, by neck incision
35005  for aneurysm, pseudoaneurysm, and associated occlusive disease, vertebral artery
35011  for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision
35013  for ruptured aneurysm, axillary-brachial artery, by arm incision
35021  for aneurysm, pseudoaneurysm, and associated occlusive disease, innominate, 
subclavian artery, by thoracic incision
35022  for ruptured aneurysm, innominate, subclavian artery, by thoracic incision
35045  for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery
35081  for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta
35082  for ruptured aneurysm, abdominal aorta
35091  for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta 
  involving visceral vessels (mesenteric, celiac, renal)
35092  for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)
35102  for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta 
  involving iliac vessels (common, hypogastric, external)
35103  for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)
35111  for aneurysm, pseudoaneurysm, and associated occlusive disease, splenic artery
35112  for ruptured aneurysm, splenic artery
35121  for aneurysm, pseudoaneurysm, and associated occlusive disease, hepatic, celiac, 
  renal or mesenteric artery
35122  for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery
35131  for aneurysm, pseudoaneurysm, and associated occlusive disease, iliac artery 
  (common, hypogastric, external)
35132  for ruptured aneurysm, iliac artery (common, hypogastric, external)
35141 for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)
35142 for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral)
35151 for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery
35152 for ruptured aneurysm, popliteal artery

REPAIR ARTERIOVENOUS FISTULA

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

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

ANGIOPLASTY

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

THROMBOENDARTERECTOMY

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

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

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

TRANSLUMINAL ANGIOPLASTY  
OPEN  

PERCUTANEOUS  

BYPASS GRAFT  
VEIN  
Procurement of the saphenous vein graft is included in the description of the work for 35501-35587  
and should not be reported as a separate service or co-surgery. To report harvesting of an upper  
extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a  
femoropopliteal vein segment, use 35572 in addition to the bypass procedure. To report harvesting  
and construction of an autogenous composite graft of two segments from two distant locations, report  
35682 in addition to the bypass procedure, for autogenous composite of three or more segments from  
distant sites, report 35683.  
35500  Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass  
   procedure  
   (List separately in addition to primary procedure)
(Use 35500 in conjunction with 33510-33536, 35556, 35566, 35571, 35583-35587)

35501 Bypass graft, with vein; common carotid-ipsilateral internal carotid
35506 carotid-subclavian or subclavian-carotid
35508 carotid-vertebral
35509 carotid-contralateral carotid
35510 carotid-brachial
35511 subclavian-subclavian
35512 subclavian-brachial
35515 subclavian-vertebral
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-po-pliteal
35558 femoral-femoral
35560 aortorenal
35563 ilioliac
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 po-pliteal-tibial, -peroneal artery or other distal vessels
35572 Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery)
(List separately in addition to primary procedure)
(Use 35572 in conjunction with code 33510-33516, 33517-33523, 33523, 33533-33536, 34502, 34520, 35001, 35002, 35011-35022, 35102, 35103, 35121-35152, 35231-35256, 35501-35587, 35879-35907)
(For bilateral procedure, use modifier -50)

IN SITU VEIN

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

OTHER THAN VEIN

35600  Harvest of upper extremity artery, one segment, for coronary artery bypass procedure
       (List separately in addition to primary procedure)
       (Use 35600 in conjunction with 33533-33536)
35601  Bypass graft, with other than vein; common carotid-ipsilateral internal carotid
35606  carotid-subclavian
35612  subclavian-subclavian
35616  subclavian-axillary
35621  axillary-femoral
35623  axillary-popliteal or -tibial
35626  aortosubclavian, aortoinnominate, or aortocarotid
35631  aortoceliac, aortomesenteric, aortorenal
35632  ilio-celiac
       (Do not report 35632 in conjunction with 35221, 35251, 35281, 35531, 35631)
35633  ilio-mesenteric
       (Do not report 35633 in conjunction with 35221, 35251, 35281, 35531, 35631)
35634  iliorenal
       (Do not report 35634 in conjunction with 35221, 35251, 35281, 35560, 35536, 35631)
35636  splenorenal (splenic to renal arterial anastomosis)
35637  aortoiliac
       (Do not report 35637 in conjunction with 35638, 35646)
35638  aortobi-iliac
       (Do not report 35638 in conjunction with 35637, 35646)
35642  carotid-vertebral
35645  subclavian-vertebral
35646  aortobifemoral
35647  aortofemoral
35650  axillary-axillary
35654  axillary-femoral-femoral
35656  femoral-popliteal
35661  femoral-femoral
35663  ilioliac
35665  iliофemoral
35666  femoral-anterior tibial, posterior 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 TRANPOSITION

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

**EXCISION, EXPLORATION, REPAIR, REVISION**

35700 Reoperation, femoral-popliteal or femoral (popliteal) - anterior tibial, posterior tibial, peroneal artery or other distal vessels, more than one month after original operation
   (List separately in addition to primary procedure)
   (Use 35700 in conjunction with 35556, 35566, 35571, 35583, 35585, 35587, 35656, 35666, 35671)
35701 Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery  
   femoral artery  
   popliteal artery  
   other vessels  
35800 Exploration for postoperative hemorrhage, thrombosis or infection; neck  
   chest  
   abdomen  
   extremity  
35870 Repair of graft-enteric fistula  
35875 Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula);  
   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  
   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)  
   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  
   extremity  
   thorax  
   abdomen  

**VASCULAR INJECTION PROCEDURES**

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

Catheters, drugs, and contrast media are not included in the listed service for the injection procedures.
Selective vascular catheterization should be coded to include introduction all lesser order selective catheterization used in the approach (eg, the description for a selective right middle cerebral artery catheterization includes the introduction and placement catheterization of the right common and internal carotid arteries).

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

**INTRAVENOUS**

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

36000 Introduction of needle or intracatheter, vein  
(For radiological vascular injection procedure not otherwise listed)

36002 Injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm  
(Do not report 36002 for vascular sealant of an arteriotomy site)

36005 Injection procedure for extremity venography (including introduction of needle or intracatheter)

36010 Introduction of catheter, superior or inferior vena cava

36011 Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)

36012  second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)

36013 Introduction of catheter, right heart or main pulmonary artery

36014 Selective catheter placement, left or right pulmonary artery

36015 Selective catheter placement, segmental or subsegmental pulmonary artery

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

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

36120 Introduction of needle or intracatheter; retrograde brachial artery

36140  extremity artery

36160 Introduction of needle or intracatheter, aortic, translumbar

36200 Introduction of catheter, aorta

36215 Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family

36216  initial second order thoracic or brachiocephalic branch, within a vascular family

36217  initial third order or more selective thoracic or brachiocephalic branch, within a vascular family

36218  additional second order, third order and beyond, thoracic or brachiocephalic branch, within a vascular family  
(List in addition to code for initial second or third order vessel as appropriate)  
(Use 36218 in conjunction with 36216, 36217)

36221 Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated
radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

(Do not report 36221 with 36222-36226)

36222 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36223 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

36224 Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

36225 Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

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

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

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

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

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

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

36248 additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family
(List in addition to code for initial second or third order vessel as appropriate)
(Use 36248 in conjunction with 36246, 36247)
36251 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

36252 bilateral

36253 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

(Do not report 36253 in conjunction with 36251 when performed for the same kidney)

36254 bilateral

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

36261 Revision of implanted intra-arterial infusion pump

36262 Removal of implanted intra-arterial infusion pump

36299 Unlisted procedure, vascular injection

VENOUS

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

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

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

36405 scalp vein

36406 other vein

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

36420 Venipuncture, cutdown; younger than age 1 year

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

36430 Transfusion, blood or blood components

36440 Push transfusion, blood, 2 years or younger

36450 Exchange transfusion, blood; newborn

36455 other than newborn

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

36460 Transfusion, intrauterine, fetal

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

36470 Injection of sclerosing solution; single vein

36471 multiple veins, same leg
36475  Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging
guidance and monitoring, percutaneous, radiofrequency; first vein treated  
36476  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  
36515  with extracorporeal immunoadsorption and plasma reinfusion  
36516  with extracorporeal selective absorption or selective filtration and plasma reinfusion  
36522  Photopheresis, extracorporeal  

CENTRAL VENOUS ACCESS PROCEDURES

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

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

1) **Insertion** (placement of catheter through a newly established venous access)  
2) **Repair** (fixing device without replacement of either catheter or port/pump, other than  
pharmacologic or mechanical correction of intracatheter or pericatheter occlusion (see 36595 or  
36596))  
3) **Partial replacement** of only the catheter component associated with a port/pump device, but not  
total 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** Insertion of non-tunneled centrally inserted central venous catheter; 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** Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older
- **36559** Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; under 5 years of age
- **36560** Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older
- **36561** Insertion of tunneled centrally inserted central venous access device, with subcutaneous port and pump
- **36562** Insertion of tunneled centrally inserted central venous access device, with subcutaneous port and pump; under 5 years of age
- **36563** Insertion of tunneled centrally inserted central venous access device, with subcutaneous port and pump; age 5 years or older
- **36564** 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)
- **36565** Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)
- **36566** Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; under 5 years of age
- **36567** Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older
- **36568** Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age
- **36569** Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older
- **36570** Insertion of peripherally inserted central venous access device, with subcutaneous port and pump

**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

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

REMOVAL OF CENTRAL VENOUS ACCESS DEVICE

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

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

OTHER CENTRAL VENOUS ACCESS PROCEDURES

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

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

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

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

36597  Repositioning of previously placed central venous catheter under fluoroscopic guidance

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

ARTERIAL

36600  Arterial puncture, withdrawal of blood for diagnosis

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

36640  Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown
  (See also 96420-96425)
36660  Catheterization, umbilical artery, newborn, for diagnosis or therapy
       (Do not report modifier 63 in conjunction with 36660)

**INTRAOSSEOUS**

36680  Placement of needle for intraosseous infusion

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

36800  Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein
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
segment, 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 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 esophageal 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
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37226 with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
37227 with transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel, when performed
37228 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty
37229 with atherectomy, includes angioplasty within the same vessel, when performed
37230 with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
37231 with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed
37232 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty
   (List separately in addition to primary procedure)
   (Use 37232 in conjunction with 37228-37231)
37233 with atherectomy, includes angioplasty within the same vessel, when performed
   (List separately in addition to primary procedure)
   (Use 37233 in conjunction with 37229-37231)
37234 with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
   (List separately in addition to primary procedure)
   (Use 37234 in conjunction with 37230, 37231)
37235 with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed
   (List separately in addition to primary procedure)
   (Use 37235 in conjunction with 37231)

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

37246 Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery
37247 each additional artery (List separately in addition to code for primary procedure)
37248 Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein
37249 each additional vein (List separately in addition to code for primary procedure)
Codes 37236, 37237 describe transluminal intravascular stent insertion into an artery while 37238, 37239 describe transluminal intravascular stent insertion in a vein. Multiple stents placed in a single vessel may only be reported with a single code. If a lesion extends across the margins of one vessel into another, but can be treated with a single therapy, the intervention should be reported only once. When additional, different vessels are treated in the same session, report 37237 and/or 37239 as appropriate. Each code in this family (37236-37239) includes any and all balloon angioplasty(s) performed in the treated vessel, including any pre-dilation (whether performed as a primary of secondary angioplasty), post dilation following stent placement, treatment of a lesion outside the stented segment but in the same vessel, or of use of larger/smaller balloon to achieve therapeutic result.

37236  Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery
37237  each additional artery (List separately in addition to code for primary procedure)
37238  Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial vein
37239  each additional vein (List separately in addition to code for primary procedure)

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

The embolization codes include all associated radiological supervision and interpretation, 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  Bone marrow; aspiration only
38221  biopsy, needle or trocar
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)
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
38589  Unlisted laparoscopy procedure, lymphatic system
RADICAL LYMPHADENECTOMY (RADICAL RESECTION OF LYMPH NODES)

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

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

INTRODUCTION

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

OTHER PROCEDURES

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

MEDIASTINUM AND DIAPHRAGM

MEDIASTINUM

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

EXCISION/RESECTION

39200  Resection of mediastinal cyst
39220  Resection of mediastinal tumor

ENDOSCOPY

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

OTHER PROCEDURES

39499  Unlisted procedure, mediastinum

DIAPHRAGM

REPAIR

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

OTHER PROCEDURES

39599  Unlisted procedure, diaphragm

DIGESTIVE SYSTEM

LIPS

EXCISION

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

**REPAIR (CHEILOPLASTY)**

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

**OTHER PROCEDURES**

40799  Unlisted procedure, lips

**VESTIBULE OF MOUTH**

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

**INCISION**

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

**EXCISION, DESTRUCTION**

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

**REPAIR**

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

OTHER PROCEDURES

40899  Unlisted procedure, vestibule of mouth

TONGUE AND FLOOR OF MOUTH

INCISION

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

EXCISION

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

**REPAIR**

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

**OTHER PROCEDURES**

41500  Fixation of tongue, mechanical, other than suture (eg, K-wire)
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  Opecturectomy, 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
        lateral lobe, with dissection and preservation of facial nerve
42415  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
        secondary or complicated
42507  Parotid duct diversion, bilateral (Wilke type procedure);
        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
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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  
43113   with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)  
43116  Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction  
43117  Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)  
43118   with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)  
43121  Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty  
43122  Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty  
43123   with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)  
43124  Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy  
43130  Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach  
43135   thoracic approach

ENDOSCOPY

43180  Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker’s diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed  
(Do not report 43180 in conjunction with 69990)  
43191  Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)  
43192   with directed submucosal injection(s), any substance  
43193   with biopsy, single or multiple  
43194   with removal of foreign body(s)  
43195   with balloon dilation (less than 30 mm diameter)  
43196   with insertion of guide wire followed by dilation over guide wire  
43197  Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)  
43198   with biopsy, single or multiple  
43200  Esophagoscopy, flexible; transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)  
43201   with directed submucosal injection(s), any substance
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43202</td>
<td>with biopsy, single or multiple</td>
</tr>
<tr>
<td>43204</td>
<td>with injection sclerosis of esophageal varices</td>
</tr>
<tr>
<td>43205</td>
<td>with band ligation of esophageal varices</td>
</tr>
<tr>
<td>43206</td>
<td>with optical endomicroscopy</td>
</tr>
<tr>
<td>43215</td>
<td>with removal of foreign body(s)</td>
</tr>
<tr>
<td>43216</td>
<td>with removal of tumor(s), polypl(s), or other lesion(s) by hot biopsy forceps</td>
</tr>
<tr>
<td>43217</td>
<td>with removal of tumor(s), polypl(s), or other lesion(s) by snare technique</td>
</tr>
<tr>
<td>43211</td>
<td>with endoscopic mucosal resection</td>
</tr>
<tr>
<td>43212</td>
<td>with placement of endoscopic stent (includes pre and post-dilation and guide wire passage, when performed)</td>
</tr>
<tr>
<td>43220</td>
<td>with transendoscopic balloon dilation (less than 30 mm diameter)</td>
</tr>
<tr>
<td>43213</td>
<td>with dilation of esophagus by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)</td>
</tr>
<tr>
<td>43214</td>
<td>with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)</td>
</tr>
<tr>
<td>43226</td>
<td>with insertion of guide wire followed by passage of dilator(s) over guide wire</td>
</tr>
<tr>
<td>43227</td>
<td>with control of bleeding, any method</td>
</tr>
<tr>
<td>43229</td>
<td>with ablation of tumor(s), polypl(s), or other lesion(s) (includes pre and post-dilation and guide wire passage, when performed)</td>
</tr>
<tr>
<td>43231</td>
<td>with endoscopic ultrasound examination (Do not report 43231 in conjunction with 76975)</td>
</tr>
<tr>
<td>43232</td>
<td>with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)</td>
</tr>
<tr>
<td>43235</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
</tr>
<tr>
<td>43236</td>
<td>with directed submucosal injection(s), any substance</td>
</tr>
<tr>
<td>43237</td>
<td>with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum and adjacent structures</td>
</tr>
<tr>
<td>43238</td>
<td>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)</td>
</tr>
<tr>
<td>43239</td>
<td>with biopsy, single or multiple</td>
</tr>
<tr>
<td>43240</td>
<td>with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed and endoscopic ultrasound, when performed)</td>
</tr>
<tr>
<td>43241</td>
<td>with insertion of intraluminal tube or catheter</td>
</tr>
<tr>
<td>43242</td>
<td>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)</td>
</tr>
<tr>
<td>43243</td>
<td>with injection sclerosis of esophageal gastric varices</td>
</tr>
<tr>
<td>43244</td>
<td>with band ligation of esophageal gastric varices</td>
</tr>
<tr>
<td>43245</td>
<td>with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie) (Do not report 43245 in conjunction with 43256)</td>
</tr>
<tr>
<td>43246</td>
<td>with directed placement of percutaneous gastrostomy tube</td>
</tr>
<tr>
<td>Code</td>
<td>Procedure Description</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>43247</td>
<td>with removal of foreign body(s)</td>
</tr>
<tr>
<td>43248</td>
<td>with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire</td>
</tr>
<tr>
<td>43249</td>
<td>with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)</td>
</tr>
<tr>
<td>43233</td>
<td>with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)</td>
</tr>
<tr>
<td>43250</td>
<td>with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps</td>
</tr>
<tr>
<td>43251</td>
<td>with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
</tr>
<tr>
<td>43252</td>
<td>with optical endomicroscopy</td>
</tr>
<tr>
<td>43253</td>
<td>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)</td>
</tr>
<tr>
<td>43254</td>
<td>with endoscopic mucosal resection</td>
</tr>
<tr>
<td>43255</td>
<td>with control of bleeding, any method</td>
</tr>
<tr>
<td>43266</td>
<td>with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)</td>
</tr>
<tr>
<td>43257</td>
<td>with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease</td>
</tr>
<tr>
<td>43270</td>
<td>with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)</td>
</tr>
<tr>
<td>43259</td>
<td>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</td>
</tr>
<tr>
<td>43210</td>
<td>with esophagogastric fundoplasmy, partial or complete, includes duodenoscopy when performed</td>
</tr>
<tr>
<td>43260</td>
<td>Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
</tr>
<tr>
<td>43261</td>
<td>with biopsy, single or multiple</td>
</tr>
<tr>
<td>43262</td>
<td>with sphincterotomy/papillotomy</td>
</tr>
<tr>
<td>43263</td>
<td>with pressure measurement of sphincter of Oddi</td>
</tr>
<tr>
<td>43264</td>
<td>with removal of calculi/debris from biliary pancreatic duct(s)</td>
</tr>
<tr>
<td>43265</td>
<td>with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)</td>
</tr>
<tr>
<td>43273</td>
<td>Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)</td>
</tr>
<tr>
<td>43274</td>
<td>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</td>
</tr>
<tr>
<td>43275</td>
<td>with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)</td>
</tr>
<tr>
<td>43276</td>
<td>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</td>
</tr>
<tr>
<td>43277</td>
<td>with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty) including sphincterotomy, when performed, each duct</td>
</tr>
</tbody>
</table>
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 fundoplassty, when performed
(Do not report 43279 in conjunction with 43280)

43280 Laparoscopy, surgical, esophagogastro fundoplassty (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)

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 Esophagogastrotomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach
43325 Esophagogastrotomy; with fundic patch (Thal-Nissen procedure)
43327 Esophagogastrotomy 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
43401 Transection of esophagus with repair, for esophageal varices
43405 Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation
43410 Suture of esophageal wound or injury; cervical approach
43415 transthoracic or transabdominal approach
43420 Closure of esophagostomy or fistula; cervical approach
43425 transthoracic or transabdominal approach

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

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

STOMACH

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

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

### LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

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

### INTRODUCTION

<table>
<thead>
<tr>
<th>Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>43752</td>
<td>Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance</td>
</tr>
<tr>
<td></td>
<td>(includes fluoroscopy, image documentation and report)</td>
</tr>
<tr>
<td></td>
<td>(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)</td>
</tr>
<tr>
<td>43753</td>
<td>Gastric intubation and aspiration(s) therapeutic, necessitating physician’s skill (eg, for gastrointestinal hemorrhage), including lavage if performed</td>
</tr>
<tr>
<td>43754</td>
<td>Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)</td>
</tr>
</tbody>
</table>
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

43760  Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance

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)

**BARIATRIC SURGERY**

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

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

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

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

43771  revision of adjustable gastric restrictive device component only

43772  removal of adjustable gastric restrictive component only

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

43774  removal of adjustable gastric restrictive device and subcutaneous port components

43775  longitudinal gastrectomy (ie, sleeve gastrectomy)

**OTHER PROCEDURES**

43800  Pyloroplasty

43810  Gastroduodenostomy

43820  Gastrojejunostomy; without vagotomy

43825  with vagotomy, any type

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

43831  neonatal, for feeding  
(Do not report modifier 63 in conjunction with 43831)

43832  with construction of gastric tube (eg, Janeway procedure)

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

INTESTINES (EXCEPT RECTUM)

INCISION

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

44100 Biopsy of intestine by capsule, tube, peroral (one or more specimens)
44110 Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy
44111 multiple enterotomies
44120 Enterectomy, resection of small intestine; single resection and anastomosis
   (Do not report 44120 in addition to 45136)
44121 each additional resection and anastomosis
   (List separately in addition to primary procedure)
   (Use 44121 in conjunction with 44120)
44125 with enterostomy
44126 Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine, without tapering
44127 with tapering
44128 each additional resection and anastomosis
   (List separately in addition to primary procedure)
   (Use 44128 in conjunction with 44126, 44127)
   (Do not report modifier 63 in conjunction with 44126, 44127, 44128)
44130 Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)
44133 Donor enterectomy, open, (with preparation and maintenance of allograft); partial, from living donor
44135 Intestinal allotransplantation; from cadaver donor
44136 from living donor
44137 Removal of transplanted intestinal allograft, complete
44139 Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)
   (Use 44139 only for codes 44140-44147)
44140 Colectomy, partial; with anastomosis
44141 with skin level cecostomy or colostomy
44143 with end colostomy and closure of distal segment (Hartmann type procedure)
44144 with resection, with colostomy or ileostomy and creation of mucofistula
44145 with coloproctostomy (low pelvic anastomosis)
44146 with coloproctostomy (low pelvic anastomosis), with colostomy
44147 abdominal and transanal approach
44150 Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy
44151 with continent ileostomy
44155 Colectomy, total, abdominal, with proctectomy; with ileostomy
44156 with continent ileostomy
44157 with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed
44158 with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed
44160 Colectomy, partial, with removal of terminal ileum with ileocolostomy
**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

**INCISION**

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

**ENTEROSTOMY-EXTERNAL FISTULIZATION OF INTESTINES**

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

**EXCISION**

44202  Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis
44203  each additional small intestine resection and anastomosis
   (List separately in addition to primary procedure)
   (Use 44203 in conjunction with code 44202)
44204  colectomy, partial, with anastomosis
44205  colectomy, partial, with removal of terminal ileum with ileocolostomy
44206  colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)
44207  colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)
44208  colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)
   with colostomy
44210  colectomy, total, abdominal, without proctectomy, with ileostomy or ileoprostectomy
44211  colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed
44212  colectomy, total, abdominal, with proctectomy, with ileostomy
44213  Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy
   (List separately in addition to primary procedure)
   (Use 44213 in conjunction with 44204-44208)

**REPAIR**

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

**OTHER PROCEDURES**

44238  Unlisted laparoscopy procedure, intestine (except rectum)
ENTEROSTOMY - EXTERNAL FISTULIZATION OF INTESTINES

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

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

44312 Revision of ileostomy; simple (release of superficial scar) (separate procedure)
44314 complicated (reconstruction in depth) (separate procedure)

44316 Continent ileostomy (Kock procedure) (separate procedure)

44320 Colostomy or skin level cecostomy;
   (Do not report 44320 in conjunction with 44141, 44144, 44146, 44605, 45110, 45119, 45125, 45805, 50810, 51597, 57307, or 58240)

44322 with multiple biopsies (eg, for congenital megacolon) (separate procedure)

44340 Revision of colostomy; simple (release of superficial scar) (separate procedure)
44345 complicated (reconstruction in depth) (separate procedure)

44346 with repair of paracolostomy hernia (separate procedure)

ENDOSCOPY, SMALL INTESTINE AND STOMAL

Surgical endoscopy always includes diagnostic endoscopy.

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

44361 with biopsy, single or multiple
44363 with removal of foreign body(s)
44364 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44365 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
44366 with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44369 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44370 with transendoscopic stent placement (includes predilation)
44372 with placement of percutaneous jejunostomy tube
44373 with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube

44376 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

44377 with biopsy, single or multiple
44378 with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44379 with transendoscopic stent placement (includes predilation)
Physician - Procedure Codes, Section 5 - Surgery

44380 Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44382 with biopsy, single or multiple
44381 with transendoscopic balloon dilation
(Do not report 44381 in conjunction with 44380,44384)
44384 with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
44385 Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44386 with biopsy, single or multiple
44388 Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44389 with biopsy, single or multiple
44390 with removal of foreign body(s)
44391 with control of bleeding, any method
44392 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
44401 with ablation of tumor(s), polyp(s), or other lesions(s), (includes pre- and post-dilation and guide wire passage, when performed)
44394 with removal of tumor(s), polyp(s), or other lesion(s) by snare techniques
44402 with endoscopic stent placement (including pre- and post-dilatation 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 enterenteric or enterocolic fistula
44660  Closure of enterovesical fistula; without intestinal or bladder resection
44661  with intestine and/or bladder resection
44680  Intestinal plication (separate procedure)

**OTHER PROCEDURES**

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

**MECKEL’S DIVERTICULUM AND THE MESENTERY**

**EXCISION**

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

**SUTURE**

44850  Suture of mesentery (separate procedure)

**OTHER PROCEDURES**

44899  Unlisted procedure, Meckel's diverticulum and the mesentery

**APPENDIX**

**INCISION**

44900  Incision and drainage of appendiceal abscess; open

**EXCISION**

44950  Appendectomy;
Physician - Procedure Codes, Section 5 - Surgery

(Incidental appendectomy during intra-abdominal surgery does not warrant a separate identification)

44955 when done for indicated purpose at time of other major procedure (not as separate procedure)

(List separately in addition to primary procedure)

44960 for ruptured appendix with abscess or generalized peritonitis

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

44970 Laparoscopy, surgical, appendectomy

44979 Unlisted laparoscopy procedure, appendix

RECTUM

INCISION

45000 Transrectal drainage of pelvic abscess

45005 Incision and drainage of submucosal abscess, rectum

45020 Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess

(See also 46050, 46060)

EXCISION

45100 Biopsy of anorectal wall, anal approach (eg, congenital megacolon)

45108 Anorectal myomectomy

45110 Proctectomy; complete, combined abdominoperineal, with colostomy

45111 partial resection of rectum, transabdominal approach

45112 Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis)

45113 Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy

45114 Proctectomy, partial, with anastomosis; abdominal and transsacral approach

45116 transsacral approach only (Kraske type)

45119 Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed

45120 Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull through procedure and anastomosis (eg, Swenson, Duhamel, or Soave type operation)

45121 with subtotal or total colectomy, with multiple biopsies

45123 Proctectomy, partial, without anastomosis, perineal approach

45126 Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof

45130 Excision of rectal procidentia, with anastomosis; perineal approach

45135 abdominal and perineal approach
45136  Excision of ileoanal reservoir with ileostomy  
(Do not report 45136 in addition to 44005, 44120, 44310)

45150  Division of stricture of rectum

45160  Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach

45171  Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)

45172  including muscularis propria (ie, full thickness)  
(For destruction of rectal tumor, transanal approach, use 45190)

DESTRUCTION

45190  Destruction of rectal tumor, (eg, electodesiccation, 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  Sigmodoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

45331  with biopsy, single or multiple
45332 with removal of foreign body(s)
45333 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45334 with control of bleeding, any method
45335 with directed submucosal injection(s), any substance
45337 with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube when performed
45338 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45346 with ablation of tumor(s), polyp(s), or other lesions(s), (includes pre- and post-dilation and guide wire passage, when performed)
45340 with transendoscopic balloon dilation
45341 with endoscopic ultrasound examination
45342 with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45347 with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
45349 with endoscopic mucosal resection
45350 with band ligation(s) (eg, hemorrhoids)
45378 Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45379 with removal of foreign body(s)
45380 with biopsy, single or multiple
45381 with directed submucosal injection(s), any substance
45382 with control of bleeding, any method
45388 with ablation of tumor(s), polyp(s), or other lesions(s), (includes pre- and post-dilation and guide wire passage, when performed)
45384 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45385 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386 with transendoscopic balloon dilation
45389 with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
45391 with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse or ascending colon and cecum, and adjacent structures
45392 with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45390 with endoscopic mucosal resection
45393 with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
45398 with band ligation(s) (eg, hemorrhoids)

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.
**EXCISION**

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

**REPAIR**

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

**REPAIR**

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

**MANIPULATION**

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

**OTHER PROCEDURES**

45399 Unlisted procedure, colon
45999 Unlisted procedure, rectum

**ANUS**

**INCISION**

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

EXCISION

46200 Fissurectomy, including sphincterotomy, when performed
46220 Excision of single external papilla or tag, anus
46221 Hemorrhoidectomy, internal, by rubber band ligation(s)
46230 Excision of multiple external papillae or tags, anus
46250 Hemorrhoidectomy, external, 2 or more columns/groups
46255 Hemorrhoidectomy, internal and external, 2 or more columns/groups;
   with fissurectomy
46258 with fistulectomy, including fissurectomy, when performed
46260 Hemorrhoidectomy, internal and external, 2 or more columns/groups;
   with fissurectomy
46261 with fistulectomy
46262 with fistulectomy, including fissurectomy, when performed
46270 Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous
   intersphincteric
46280 transspincteric, supraspincteric, extraspincteric or multiple, including placement of seton, when performed
   (Do not report 46280 in conjunction with 46020)
46282 second stage
46288 Closure of anal fistula with rectal advancement flap
46320 Excision of thrombosed hemorrhoid, external

INTRODUCTION

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

ENDOSCOPY

(Surgical endoscopy always includes diagnostic endoscopy)

46600 Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
46601 diagnostic, with high resolution magnification (HRA) (eg,
colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed

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

REPAIR

46700 Anoplasty, plastic operation for stricture; adult
46705 infant
46706 Repair of anal fistula with fibrin glue
46707 Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])
46710 Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach
46712 combined transperineal and transabdominal approach
46715 Repair of low imperforate anus; with anoperineal fistula (cut-back procedure)
46716 with transposition of anoperineal or anovestibular fistula
46730 Repair of high imperforate anus without fistula; perineal or sacroperineal approach
46735 combined transabdominal and sacroperineal approaches
46740 Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach
46742 combined transabdominal and sacroperineal approaches
46744 Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty; sacroperineal approach
46746 Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach
46748 with vaginal lengthening by intestinal graft and pedicle flaps
46750 Sphincteroplasty, anal, for incontinence or prolapse; adult
46751 child
46753 Graft (Thiersch operation) for rectal incontinence and/or prolapse
46754 Removal of Thiersch wire or suture, anal canal
46760 Sphincteroplasty, anal, for incontinence, adult; muscle transplant
46761  levator muscle imbrication (Park posterior anal repair)
46762  implantation artificial sphincter

DESTRUCTION

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

SUTURE

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

OTHER PROCEDURES

46999  Unlisted procedure, anus

LIVER

INCISION

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

EXCISION

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

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

REPAIR

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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

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

OTHER PROCEDURES

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

BILIARY TRACT

INCISION

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

INTRODUCTION

47490 Cholecystotomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation
47531 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access

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

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

47534 internal-external

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

47536 Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation
(Do not report 47536 in conjunction with 47538 for the same access)
(47536 includes exchange of one catheter. For exchange of additional catheter[s]during the same session, report 47536 with modifier 59 for each additional exchange)

47537 Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation

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

47539 new access, without placement of separate biliary drainage catheter

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

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

47542 Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, each duct (List separately in addition to code for primary procedure)
(Use 47542 in conjunction with 47531, 47532, 47533, 47534, 47535, 47536, 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 intrap hepatic
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 Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)
49255 Omentectomy, epiploectomy, resection of omentum (separate procedure)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

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

49329 Unlisted laparoscopy procedure, abdomen, peritoneum and omentum

**INTRODUCTION, REVISION AND/OR REMOVAL**

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

INITIAL PLACEMENT

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

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

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

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

CONVERSION

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

REPLACEMENT

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

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

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

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

MECHANICAL REMOVAL OF OBSTRUCTIVE MATERIAL

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

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

REPAIR

HERNIOPLASTY, HERNIORRHAPHY, HERNIOTOMY

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

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

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

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

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

LAPAROSCOPY
Surgical laparoscopy always includes diagnostic laparoscopy.

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

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

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

**URINARY SYSTEM**

**KIDNEY**

**INCISION**

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

**EXCISION**

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

**RENUAL TRANSPLANTATION**

50320  Donor nephrectomy (including cold preservation); open, from living donor
50340  Recipient nephrectomy (separate procedure)
(For bilateral procedure, report 50340 with modifier 50)

50360 Renal allotransplantation, implantation of graft; without recipient nephrectomy
50365 with recipient nephrectomy
50370 Removal of transplanted renal allograft
50380 Renal autotransplantation, reimplantation of kidney

INTRODUCTION

RENAL PELVIS CATHETER PROCEDURES

INTERNALLY DWELLING

50382 Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation
50384 Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation
(Do not report 50382, 50384 in conjunction with 50395)
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)
50395 Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous
50396 Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter
50430 Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access
50431 existing access
(Do not report 50430, 50431 in conjunction with 50432, 50433, 50434, 50435, 50693, 50694, 50695, 74425 for the same renal collecting system and/or associated ureter)
50432 Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation

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

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

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

REPAIR

50400 Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple

50405 complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calycoplasty)

50500 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 Ureteroenterostomy, direct anastomosis of ureter to intestine
50810 Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis
50815 Ureterocolon conduit, including intestine anastomosis
50820 Ureteroileal conduit (ileal bladder), including intestine anastomosis (Bricker operation)
50825 Continent diversion, including intestine anastomosis using any segment of small and/or large bowel (Kock pouch or Camey enterocystoplasty)
50830 Urinary undiversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroureterostomy or ureteroneocystostomy)
50840 Replacement of all or part of ureter by intestine segment, including intestine anastomosis
50845 Cutaneous appendico-vesicostomy
50860 Ureterostomy, transplantation of ureter to skin
50900 Ureterorrhaphy, suture of ureter (separate procedure)
50920 Closure of ureterocutaneous fistula
50930 Closure of ureterovisceral fistula (including visceral repair)
50940 Delegation of ureter

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

50945 Laparoscopy, surgical; ureterolithotomy
50947 ureteroneocystostomy with cystoscopy and ureteral stent placement
50948 ureteroneocystostomy without cystoscopy and ureteral stent placement
50949 Unlisted laparoscopic procedure, ureter

**ENDOSCOPY**

50951 Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50953 with ureteral catheterization, with or without dilation of ureter
50955 with biopsy
50957 with fulguration and/or incision, with or without biopsy
50961 with removal of foreign body or calculus
50970 Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50972 with ureteral catheterization, with or without dilation of ureter
50974 with biopsy
50976 with fulguration and/or incision, with or without biopsy
50980 with removal of foreign body or calculus

(When procedures 50970-50980 provide a significant identifiable service, they may be added to 50600)

**BLADDER**

**INCISION**

51020 Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>51030</td>
<td>with cryosurgical destruction of intravesical lesion</td>
</tr>
<tr>
<td>51040</td>
<td>Cystostomy, cystotomy with drainage</td>
</tr>
<tr>
<td>51045</td>
<td>Cystotomy, with insertion of ureteral catheter or stent (separate procedure)</td>
</tr>
<tr>
<td>51050</td>
<td>Cystolithotomy, cystotomy with removal of calculus, without vesical neck resection</td>
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<tr>
<td>51060</td>
<td>Transvesical ureterolithotomy</td>
</tr>
<tr>
<td>51065</td>
<td>Cystotomy, with calculus basket extraction and/or ultrasonic or electrohydraulic fragmentation of ureteral calculus</td>
</tr>
<tr>
<td>51080</td>
<td>Drainage of perivesical or prevesical space abscess</td>
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<td></td>
<td><strong>REMOVAL</strong></td>
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<tr>
<td>51100</td>
<td>Aspiration of bladder; by needle</td>
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<tr>
<td>51101</td>
<td>by trocar or intracatheter</td>
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<tr>
<td>51102</td>
<td>with insertion of suprapubic catheter</td>
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<td></td>
<td><strong>EXCISION</strong></td>
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<tr>
<td>51500</td>
<td>Excision of urachal cyst or sinus, with or without umbilical hernia repair</td>
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<tr>
<td>51520</td>
<td>Cystotomy; for simple excision of vesical neck (separate procedure)</td>
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<tr>
<td>51525</td>
<td>for excision of bladder diverticulum, single or multiple (separate procedure)</td>
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<tr>
<td>51530</td>
<td>for excision of bladder tumor</td>
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<tr>
<td>51535</td>
<td>Cystotomy for excision, incision, or repair of ureterocele (For bilateral procedure, use modifier -50)</td>
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<tr>
<td>51550</td>
<td>Cystectomy, partial; simple</td>
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<tr>
<td>51555</td>
<td>complicated (eg, postradiation, previous surgery, difficult location)</td>
</tr>
<tr>
<td>51565</td>
<td>Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)</td>
</tr>
<tr>
<td>51570</td>
<td>Cystectomy, complete; (separate procedure)</td>
</tr>
<tr>
<td>51575</td>
<td>with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes</td>
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<tr>
<td>51580</td>
<td>Cystectomy, complete with ureterosigmoidostomy or ureterocutaneous transplantations;</td>
</tr>
<tr>
<td>51585</td>
<td>with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes</td>
</tr>
<tr>
<td>51590</td>
<td>Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis;</td>
</tr>
<tr>
<td>51595</td>
<td>with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes</td>
</tr>
<tr>
<td>51596</td>
<td>Cystectomy, complete, with continent diversion, any technique, using any segment of small and/or large intestine to construct neobladder</td>
</tr>
<tr>
<td>51597</td>
<td>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</td>
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<tr>
<td></td>
<td><strong>INTRODUCTION</strong></td>
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<tr>
<td>51600</td>
<td>Injection procedure for cystography or voiding urethrocystography</td>
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<tr>
<td>51605</td>
<td>Injection procedure and placement of chain for contrast and/or chain urethrocystography</td>
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<tr>
<td>51610</td>
<td>Injection procedure for retrograde urethrocystography</td>
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</table>
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
51729  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; with hysterectomy (See Rule 14)
51990  Laparoscopy, surgical; urethral suspension for stress incontinence
51992  sling operation for stress incontinence (eg, fascia or synthetic)
51999  Unlisted laparoscopy procedure, bladder

**LAPAROSCOPY**
Surgical laparoscopy always includes diagnostic laparoscopy.

51900  Laparoscopy, surgical; urethral suspension for stress incontinence
5192  sling operation for stress incontinence (eg, fascia or synthetic)
51999  Unlisted laparoscopy procedure, bladder

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

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

**TRANSURETHRAL SURGERY**

**URETHRA AND BLADDER**

52204  Cystourethroscopy, with biopsy(s)
52214  Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
52224  Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s), with or without biopsy
52234 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)
52235 MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52240 LARGE bladder tumor(s)
52250 Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration
52260 Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
52265 local anesthesia
52270 Cystourethroscopy, with internal urethrotomy; female
52275 male
52276 Cystourethroscopy, with direct vision internal urethrotomy
52277 Cystourethroscopy, with resection of external sphincter (sphincterotomy)
52281 Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
52282 Cystourethroscopy, with insertion of permanent urethral stent
52283 Cystourethroscopy, with steroid injection into stricture
52284 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 cystourethoscopic with ureteroscopy and/or pyeloscopy is included in 52320-52355 and should not be reported separately.
52320 Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus
52325 with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)
52327 with subureteric injection of implant material
52330 with manipulation, without removal of ureteral calculus
52332 Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
52334 Cystourethroscopy, with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde
52341 Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)
52342 with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)
52343 with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)
52344 Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)
52345 with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)
52346 with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)
52351 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic (Do not report 52351 in conjunction with 52341-52346, 52352-52355)
52352 with removal or manipulation of calculus (ureteral catheterization is included)
52353 with lithotripsy (ureteral catheterization is included)
52354 with biopsy and/or fulguration of ureteral or renal pelvic lesion
52355 with resection of ureteral or renal pelvic tumor
52356 with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

VESICAL NECK AND PROSTATE

52400 Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds
52402 Cystourethroscopy with transurethral resection or incision of ejaculatory ducts
52441 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant
52542 each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)
52450 Transurethral incision of prostate
52500 Transurethral resection of bladder neck (separate procedure)
52601 Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52630 Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52640 of postoperative bladder neck contracture
52647 Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)
52648 Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)
52649 Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)
(Do not report 52649 in conjunction with 52000, 52276, 52281, 52601, 52647, 52648, 53020, 55250)
52700 Transurethral drainage of prostatic abscess

URETHRA

INCISION

53000 Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra
53010 perineal urethra, external
53020 Meatotomy, cutting of meatus (separate procedure); except infant
53025 infant
(Do not report modifier -63 in conjunction with 53025)
53040 Drainage of deep periurethral abscess
53060 Drainage of Skene's gland abscess or cyst
53080 Drainage of perineal urinary extravasation; uncomplicated (separate procedure)
53085 complicated

EXCISION

53200 Biopsy of urethra
53210 Urethrectomy, total, including cystostomy; female
53215 male
53220 Excision or fulguration of carcinoma of urethra
53230 Excision of urethral diverticulum (separate procedure); female
53235 male
53240 Marsupialization of urethral diverticulum, male or female
53250 Excision of bulbourethral gland (Cowper's gland)
53260 Excision or fulguration; urethral polyp(s), distal urethra
53265 urethral caruncle
53270 Skene's glands
53275 urethral prolapse

REPAIR

53400 Urethroplasty; first stage, for fistula, diverticulum, or stricture, (eg, Johannsen type)
53405 second stage (formation of urethra), including urinary diversion
53410 Urethroplasty, one-stage reconstruction of male anterior urethra
53415 Urethroplasty, transpubic or perineal, one stage, for reconstruction or repair of prostatic or membranous urethra
53420 Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage
      second stage
53430 Urethroplasty, reconstruction of female urethra
53431 Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg, Tenago, Leadbetter procedure)
53440 Sling operation for correction of male urinary incontinence, (eg, fascia or synthetic)
53442 Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)
53444 Insertion of tandem cuff (dual cuff)
53445 Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
53446 Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53447 Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir and cuff at the same operative session
53448 Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue
      (Do not report 11043 in addition to 53448)
53449 Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53450 Urethromeatoplasty, with mucosal advancement
53460 Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
53500 Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring)
      (Do not report 53500 in conjunction with 52000)
53502 Urethorrhaphy, suture of urethral wound or injury; female
      penile
      perineal
      prostatomembranous
53520 Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)

**MANIPULATION**

53600 Dilation of urethral stricture by passage of sound or urethral dilator, male; initial
      subsequent
53605 Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia
53620 Dilation of urethral stricture by passage of filiform and follower, male; initial
      subsequent
53660 Dilation of female urethra including suppository and/or instillation; initial
      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 electrodesiccation
54056 cryosurgery
54057 laser surgery
54060 surgical excision
54065 Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

EXCISION

54100 Biopsy of penis; (separate procedure)
54105 deep structures
54110 Excision of penile plaque (Peyronie disease);
54111 with graft to 5 cm in length
54112 with graft greater than 5 cm in length
54115 Removal foreign body from deep penile tissue (eg, plastic implant)
54120 Amputation of penis; partial
54125 complete
54130 Amputation of penis, radical; with bilateral inguinalfemoral lymphadenectomy
54135 in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
54150 Circumcision, using clamp or other device with regional dorsal penile or ring block
(Do not report modifier 63 in conjunction with 54150)
54160 Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less)
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 modifier 63 in conjunction with 54160)

INTRODUCTION

54200 Injection procedure for Peyronie disease;
54205 with surgical exposure of plaque
54220 Irrigation of corpora cavernosa for priapism
54230 Injection procedure for corpora cavernosography
54240 Penile plethysmography
54250 Nocturnal penile tumescence and/or rigidity test

REPAIR

54300 Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra
54304 Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps
54308 Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm
54312 greater than 3 cm
54316 Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia
54318 Urethroplasty for third stage hypospadias repair to release penis from scrotum (eg, 3rd stage Cecil repair)
54322 One stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V-flap)
54324 with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap)
54326 with urethroplasty by local skin flaps and mobilization of urethra
54328 with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap
54332 One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap
54336 One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap
54340 Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple
54344 requiring mobilization of skin flaps and urethroplasty with flap or patch graft
54348 requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)
54352  Repair of hypospadias cripple requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as flaps or grafts
54360  Plastic operation on penis to correct angulation
54380  Plastic operation on penis for epispadias distal to external sphincter; with incontinence
54390  with exstrophy of bladder
54400  Insertion of penile prosthesis; non-inflatable (semi-rigid)  
54401  inflatable (self-contained)
54405  Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406  Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408  Repair of component(s) of a multi-component, inflatable penile prosthesis
54410  Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411  Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue  
(Do not report 11043 in addition to 54411)
54415  Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416  Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417  Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue  
(Do not report 11043 in addition to 54417)
54420  Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral
54430  Corpora cavernosa-corpis spongiosum shunt (priapism operation), unilateral or bilateral
54435  Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism
54437  Repair of traumatic corporeal tear(s)
54438  Replantation, penis, complete amputation including urethral repair
54440  Plastic operation of penis for injury

MANIPULATION

54450  Foreskin manipulation including lysis of preputial adhesions and stretching

TESTIS

EXCISION

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

EXPLORATION

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

REPAIR

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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.
54690  Laparoscopy, surgical; orchiectomy
54692   orchiopexy for intra-abdominal testis
54699  Unlisted laparoscopy procedure, testis

EPIDIDYMIS

INCISION

54700  Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)

EXCISION

54800  Biopsy of epididymis, needle
54830  Excision of local lesion of epididymis
54840  Excision of spermatocele, with or without epididymectomy
54860  Epididymectomy; unilateral
54861   bilateral
EXPLORATION
54865 Exploration of epididymis, with or without biopsy

TUNICA VAGINALIS

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

EXCISION
55040 Excision of hydrocele; unilateral
55041 bilateral

REPAIR
55060 Repair of tunica vaginalis hydrocele (Bottle type)

SCROTUM

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

EXCISION
55150 Resection of scrotum

REPAIR
55175 Scrotoplasty; simple
55180 complicated

VAS DEFERENS

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

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

SUTURE
55450  Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)

**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
19304: Mastectomy, subcutaneous
19324: Mammoplasty, augmentation; without prosthetic implant
19325: with prosthetic implant

For male-to-female gender reassignment, augmentation mammoplasty may be considered medically necessary for individuals with a diagnosis of gender dysphoria when that individual does not have any breast growth after 24 months of cross-sex hormone therapy, or in instances where hormone therapy is medically contraindicated.

54520: Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54522: Orchiectomy, partial
58150: Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58152: with colpo-urethrocystopexy (e.g., Marshall-Machetti-Krantz, Burch)
58180: Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260: Vaginal hysterectomy, for uterus 250 grams or less;
58262: with removal of tube(s), and/or ovary(s)
58263: with removal of tube(s), and/or ovary(s), with repair of enterocele
58267: with colpo-urethrocystopexy (Marshall-Marchetti-Krantz Type, Pereyra type, with or without endoscopic control)
58270: with repair of enterocele
58275: Vaginal hysterectomy, with total or partial vaginectomy;
58280: with repair of enterocele
58285: Vaginal hysterectomy, radical (Schauta type operation)
58290: Vaginal hysterectomy, for uterus greater than 250 grams;
58291: with removal of tube(s) and/or ovary(s)
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 (supracciliary, 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 inguinofermal lymphadenectomy
- **56632**: with bilateral inguinofermal lymphadenectomy
- **56633**: Vulvectomy, radical, complete;
- **56634**: with unilateral inguinofermal lymphadenectomy
- **56637**: with bilateral inguinofermal lymphadenectomy
- **56640**: Vulvectomy, radical, complete, with inguinofermal, 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 lymphaadenectomy 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 lymphaadenectomy 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
57250  Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy
57260  Combined anteroposterior colporrhaphy;
      with enterocele repair
57267  Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach
      (List separately in addition to primary procedure)
      (Use 57267 in addition to 45560, 57240-57265)
57268  Repair of enterocele, vaginal approach (separate procedure)
57270  Repair of enterocele, abdominal approach (separate procedure)
57280  Colpopexy, abdominal approach
57282  Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)
57283  intra-peritoneal approach (uterosacral, levator myorrhaphy)
57284  Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach
      (Do not report 57284 in conjunction with 51840, 51841, 51990, 57240, 57260, 57265, 58152, 58267)
57285  vaginal approach
      (Do not report 57285 in conjunction with 51990, 57240, 57260, 57265, 58267)
57287  Removal or revision of sling for stress incontinence (eg, fascia or synthetic)
57288  Sling operation for stress incontinence (eg, fascia or synthetic)
57289  Pereyra procedure, including anterior colporrhaphy
57291  Construction of artificial vagina; without graft
57292  with graft
57295  Revision (including removal) of prosthetic vaginal graft, vaginal approach
57296  open abdominal approach
57300  Closure of rectovaginal fistula; vaginal or transanal approach
57305  abdominal approach
57307  abdominal approach, with concomitant colostomy
57308  transperineal approach, with perineal body reconstruction, with or without levator plication
57310  Closure of urethrovaginal fistula;
57311  with bulbocavernosus transplant
57320  Closure of vesicovaginal fistula; vaginal approach
57330  transvesical and vaginal approach
57335  Vaginoplasty for intersex state

MANIPULATION

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

ENDOSCOPY

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

CERVIX UTERI

ENDOSCOPY

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

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

Vaginal hysterectomy, with total or partial vaginectomy;

58275  with repair of enterocele

Vaginal hysterectomy, radical (Schauta type operation)

Vaginal hysterectomy, for uterus greater than 250 grams;

58290  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)

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;
Physician - Procedure Codes, Section 5 - Surgery

58951  with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy
58952  with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal
      or retroperitoneal tumors)
58953  Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and
      radical dissection for debulking;
58954  with pelvic lymphadenectomy and limited para-aortic lymphadenectomy
58956  Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for
      malignancy
      (Do not report 58956 in conjunction with 49255, 58150, 58180, 58262, 58263, 58550, 58661,
      58700, 58720, 58900, 58925, 58940, 58957, 58958)
58957  Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine
      malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;
58958  with pelvic lymphadenectomy and limited para-aortic lymphadenectomy
      (Do not report 58957, 58958 in conjunction with 38770, 38780, 44005, 49000, 49203-49215,
      49255, 58900-58960)
58960  Laparotomy, for staging or restaging of ovarian, tubal or primary peritoneal malignancy
      (second look), with or without omentectomy, peritoneal washing, biopsy of abdominal and
      pelvic peritoneum, diaphragmatic assessment with pelvic and limited para-aortic
      lymphadenectomy
      (Do not report 58960 in conjunction with 58957, 58958)
58999  Unlisted procedure, female genital system, nonobstetrical

MATERNITY CARE AND DELIVERY

The services normally provided in uncomplicated maternity cases include antepartum care, delivery,
and postpartum care.

Antepartum care includes the initial and subsequent history, physical examinations, recording of
weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28
weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Any other
visits or services within this time period should be coded separately.

Delivery services include admission to the hospital, the admission history and physical examination,
management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without
forceps), or cesarean delivery. Medical problems complicating labor and delivery management may
require additional resources and should be identified by utilizing the codes in the Medicine and E/M
Services section in addition to codes for maternity care.

Postpartum care includes hospital and office visits following vaginal or cesarean section delivery.

For medical complications of pregnancy (eg, cardiac problems, neurological problems, diabetes,
hypertension, toxemia, hyperemesis, pre-term labor, premature rupture of membranes), see services
in the Medicine and E/M Services section. For surgical complications of pregnancy (eg,
appendectomy, hernia, ovarian cyst, Bartholin cyst), see services in the Surgery section.

If a physician provides all or part of the antepartum and/or postpartum patient care but does not
perform delivery due to termination of pregnancy by abortion or referral to another physician for
delivery, see the antepartum and postpartum care codes 59425-59426 and 59430.
Reimbursement amounts for the Medicaid Obstetrical and Maternal Services Program (MOMS), are noted in the Enhanced Program excel Fee Schedule. For information on the MOMS Program, see Policy Section.

**FETAL INVASIVE SERVICES**

59000 Amniocentesis; diagnostic
59001 therapeutic amniotic fluid reduction (includes ultrasound guidance)
59012 Cordocentesis (intrauterine), any method
59015 Chorionic villus sampling, any method
59020 Fetal contraction stress test
59025 Fetal non-stress test
59030 Fetal scalp blood sampling
59050 Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation
59070 Transabdominal amnioinfusion, including ultrasound guidance
59072 Fetal umbilical cord occlusion, including ultrasound guidance
59074 Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance
59076 Fetal shunt placement, including ultrasound guidance

**EXCISION**

*(For code 59135, See Rule 14, Receipt of Hysterectomy Information)*

59100 Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)
(When tubal ligation is performed at the same time as hysterotomy, use 58611 in addition to 59100)
59120 Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach
59121 tubal or ovarian, without salpingectomy and/or oophorectomy
59130 abdominal pregnancy
59135 interstitial, uterine pregnancy requiring total hysterectomy
59136 interstitial, uterine pregnancy with partial resection of uterus
59140 cervical, with evacuation
59150 Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy
59151 with salpingectomy and/or oophorectomy
59160 Curettage, postpartum

**INTRODUCTION**

59200 Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)

**REPAIR**

59300 Episiotomy or vaginal repair, by other than attending
59320 Cerclage of cervix, during pregnancy; vaginal
59325 abdominal
VAGINAL DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

59400 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and (inpatient and outpatient) postpartum care (total, all-inclusive, "global" care)

59409 Vaginal delivery only (with or without episiotomy and/or forceps); (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)

59410 including (inpatient and outpatient) postpartum care

59412 External cephalic version, with or without tocolysis

59414 Delivery of placenta (separate procedure)
(For antepartum care only, see 59425, 59426 or appropriate E/M code(s))
(For 1-3 antepartum care visits, see appropriate E/M code(s))

59425 Antepartum care only; 4-6 visits

59426 7 or more visits
(For 6 or less antepartum encounters, see code 59425)

Note: Antepartum services will no longer require prorated charges. This applies to all prenatal care providers, including those enrolled in the MOMS program. Providers should bill one unit of the appropriate antepartum code after all antepartum care has been rendered using the last antepartum visit as the date of service. Only one antepartum care code will be reimbursed per pregnancy.

59430 Postpartum care only (outpatient) (separate procedure)

CESAREAN DELIVERY

59510 Routine obstetric care including antepartum care, cesarean delivery, and (inpatient and outpatient) postpartum care (total, all-inclusive, "global" care)

59514 Cesarean delivery only; (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)

59515 including (inpatient and outpatient) postpartum care

59525 Subtotal or total hysterectomy after cesarean delivery (See Rule 14)
(List separately in addition to primary procedure)
(Use 59525 in conjunction with 59510, 59514, 59515, or 59618, 59620, 59622)

DELIVERY AFTER PREVIOUS CESAREAN DELIVERY

Patients who have had a previous cesarean delivery and now present with the expectation of a vaginal delivery are coded using codes 59610-59622. If the patient has a successful vaginal delivery after a previous cesarean delivery (VBAC), use codes 59610-59614. If the attempt is unsuccessful and another cesarean delivery is carried out, use codes 59618-59622. To report elective cesarean deliveries use code 59510, 59514 or 59515.

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and (inpatient and outpatient) postpartum care, after previous cesarean delivery (total, all-inclusive, "global" care)
59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)

59614 including (inpatient and outpatient) postpartum care

59618 Routine obstetric care including antepartum care, cesarean delivery, and (inpatient and outpatient) postpartum care, following attempted vaginal delivery after previous cesarean delivery (total, all-inclusive, "global" care)

59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)

59622 including (inpatient and outpatient) postpartum care

**ABORTION**

(Ultrasound service(s) provided in conjunction with procedure codes 59812 through 59857 are reimbursable ONLY via echography code 76815. Procedure code 76815 should be billed regardless of the approach used to perform the ultrasound (eg, transvaginal))

59812 Treatment of incomplete abortion, any trimester, completed surgically

59820 Treatment of missed abortion, completed surgically; first trimester

59821 second trimester

59830 Treatment of septic abortion, completed surgically

59840 Induced abortion, by dilation and curettage

59841 Induced abortion, by dilation and evacuation

59850 Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;

59851 with dilation and curettage and/or evacuation

59852 with hysterotomy (failed intra-amniotic injection)

59855 Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;

59856 with dilation and curettage and/or evacuation

59857 with hysterotomy (failed medical evaluation)

**OTHER PROCEDURES**

59870 Uterine evacuation and curettage for hydatidiform mole

59871 Removal of cerclage suture under anesthesia (other than local)

59897 Unlisted fetal invasive procedure, including ultrasound guidance, when performed

59898 Unlisted laparoscopy procedure, maternity care and delivery

59899 Unlisted procedure, maternity care and delivery

**ENDOCRINE SYSTEM**

**THYROID GLAND**

**INCISION**
60000 Incision and drainage of thyroglossal duct cyst, infected

**EXCISION**

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

**REMOVAL**

60300 Aspiration and/or injection, thyroid cyst

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

**EXCISION**

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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

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

OTHER PROCEDURES

60699  Unlisted procedure, endocrine system

NERVOUS SYSTEM

SKULL, MENINGES, AND BRAIN

INJECTION, DRAINAGE OR ASPIRATION

61000  Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initial
61001   subsequent taps
61020  Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection
61026   with injection of medicament or other substance for diagnosis or treatment
61050  Cisternal or lateral cervical (C1-C2) puncture; without injection (separate procedure)
61055   with injection of medication or other substance for diagnosis or treatment
61070  Puncture of shunt tubing or reservoir for aspiration or injection procedure
   (For radiological supervision and interpretation, use 75809)

TWIST DRILL, BURR HOLE(S) OR TREPHINE

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

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

CRANIECTOMY OR CRANIOTOMY

61304 Craniectomy or craniotomy, exploratory; supratentorial
61305 infratentorial (posterior fossa)
61312 Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural
61313 intracerebral
61314 Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural
61315 intracerebellar
61316 Incision and subcutaneous placement of cranial bone graft
   (List separately in addition to primary procedure)
   (Use 61316 in conjunction with codes 61304, 61312, 61313, 61322, 61323, 61340, 61570, 61571, 61680-61705)
61320 Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial
61321 infratentorial
61322 Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy
61323 with lobectomy
   (Do not report 61313 in addition to 61322, 61323)
61330 Decompression of orbit only, transcranial approach
   (For bilateral procedure, use modifier -50)
61332 Exploration of orbit (transcranial approach); with biopsy
61333 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
61480 for mesencephalic tractotomy or pedunculotomy
61500 Craniectomy; with excision of tumor or other bone lesion of skull
61501 for osteomyelitis
61510 Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma

61512 for excision of meningioma, supratentorial

61514 for excision of brain abscess, supratentorial

61516 for excision or fenestration of cyst, supratentorial

61517 Implantation of brain intracavitary chemotherapy agent
(List separately in addition to primary procedure)
(Use 61517 only in conjunction with codes 61510 or 61518)
(Do not report 61517 for brachytherapy insertion. For intracavitary insertion of radioelement sources or ribbons, see 77781-77784)

61518 Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull

61519 meningioma

61520 cerebellopontine angle tumor

61521 midline tumor at base of skull

61522 Craniectomy, infratentorial or posterior fossa; for excision of brain abscess

61524 for excision or fenestration of cyst

61526 Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;

61530 combined with middle/posterior fossa craniotomy/craniectomy

61531 Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring

61533 Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring

61534 for excision of epileptogenic focus without electrocorticography during surgery

61535 for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)

61536 for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)

61537 for lobectomy, temporal lobe, without electrocorticography during surgery

61538 for lobectomy, temporal lobe, with electrocorticography during surgery

61539 for lobectomy, other than temporal lobe, partial or total with electrocorticography during surgery

61540 for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery

61541 for transection of corpus callosum

61543 for partial or subtotal (functional) hemispherectomy

61544 for excision or coagulation of choroid plexus

61545 for excision of craniopharyngioma

61546 Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach

61548 Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic

61550 Craniectomy for craniosynostosis; single cranial suture

61552 multiple cranial sutures

61556 Craniotomy for craniosynostosis; frontal or parietal bone flap
61557 bifrontal bone flap
61558 Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); not requiring bone grafts
61559 recounting with multiple osteotomies and bone autografts (eg, barrel-stave procedure) (includes obtaining grafts)
61563 Excision, intra- and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); without optic nerve decompression
61564 with optic nerve decompression
61566 Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy
61567 for multiple subpial transections, with electrocorticography during surgery
61570 Craniectomy or craniotomy; with excision of foreign body from brain
61571 with treatment of penetrating wound of brain
61575 Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion;
61576 requiring splitting of tongue and/or mandible (including tracheostomy)

SURGERY OF SKULL BASE

The surgical management of lesions involving the skull base (base of anterior, middle and posterior cranial fossae) often requires the skills of several surgeons of different surgical specialties working together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of dura, subcutaneous tissues and skin to avoid serious infections such as osteomyelitis and/or meningitis.

The procedures are categorized according to 1) approach procedure necessary to obtain adequate exposure to the lesion (pathologic entity), 2) definitive procedure(s) necessary to biopsy, excise or otherwise treat the lesion, and 3) repair/reconstruction of the defect present following the definitive procedure(s).

The approach procedure is described according to anatomical area involved, ie, anterior cranial fossa, middle cranial fossa, posterior cranial fossa and brain stem or upper spinal cord.

The definitive procedure(s) describes the repair, biopsy, resection or excision of various lesions of the skull base and, when appropriate, primary closure of the dura, mucous membranes and skin.

The repair/reconstruction procedure(s) is reported separately if extensive dural grafting, cranioplasty, local or regional myocutaneous pedicle flaps, or extensive skin grafts are required.

When one surgeon performs the approach procedure, another surgeon performs the definitive procedure, and another surgeon performs the repair/reconstruction procedure, each surgeon reports only the code for the specific procedure performed.

APPROACH PROCEDURES

61580 Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration
61581 extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy
61582 extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa
61583 intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa
61584 Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); without orbital exenteration
61585 with orbital exenteration
61586 Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft
61589 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
61590 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
61591 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
61592 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
61593 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
61594 Transcondylar (far lateral) approach to posterior cranial fossa, jugular foramen or midline skull base including occipital condylectomy, mastoidectomy, resection of Cl-C3 vertebral body(s), decompression of vertebral artery, with or without mobilization
61595 Transtemporal approach to posterior cranial fossa, jugular foramen or midline skull base, including mastoidectomy, decompression of sigmoid sinus and/or facial nerve, with or without mobilization
61596 Transcochlear approach to posterior cranial fossa, jugular foramen or midline skull base, including labyrinthectomy, decompression, with or without mobilization of facial nerve and/or petrous carotid artery
61597 Transcondylar (far lateral) approach to posterior cranial fossa, jugular foramen or midline skull base including occipital condylectomy, mastoidectomy, resection of Cl-C3 vertebral body(s), decompression of vertebral artery, with or without mobilization
61598 Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus

DEFINITIVE PROCEDURES

61600 Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; extradural
61601 intradural, including dural repair, with or without graft
61605 Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural
61606 intradural, including dural repair, with or without graft
61607 Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural
61608 intradural, including dural repair, with or without graft
61610 with repair by anastomosis or graft
   (List separately in addition to primary procedure)
61611 Transection or ligation, carotid artery in petrous canal; without repair
61612  with repair by anastomosis or graft
   (List separately in addition to primary procedure)
   (Code 61612 are reported in addition to code(s) for primary procedure(s) 61605-61608).
   Report only one transection or ligation of carotid artery code per operative session)
61613 Obliteration of carotid aneurysm, arteriovenous malformation, or carotid-cavernous fistula by
dissection within cavernous sinus
61615 Resection or excision of neoplastic vascular or infectious lesion of base of posterior cranial
fossa, jugular foramen, foramen magnum, or CI-C3 vertebral bodies; extradural
61616 intradural, including dural repair, with or without graft

REPAIR AND/OR RECONSTRUCTION OF SURGICAL DEFECTS OF SKULL BASE

61618 Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial
fossa following surgery of the skull base; by free tissue graft (eg, pericranium, fascia, tensor
fascia lata, adipose tissue, homologous or synthetic grafts)
61619 by local or regionalized vascularized pedicle flap or myocutaneous flap (including galea,
temporalis, frontalis or occipitalis muscle)

ENDOVASCULAR THERAPY

61623 Endovascular temporary balloon arterial occlusion, head or neck (extracranial/intracranial)
including selective catheterization of vessel to be occluded, positioning and inflation of
occlusion balloon, concomitant neurological monitoring, and radiologic supervision and
interpretation of all angiography required for balloon occlusion and to exclude vascular injury
post occlusion
61624 Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve
hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous
system (intracranial, spinal cord)
   (See also 37204)
61626 non-central nervous system, head or neck (extracranial, brachiocephalic branch)
   (See also 37204)
61630 Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous
61635 Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis),
including balloon angioplasty, if performed
   (61630 and 61635 include all selective vascular catheterization of the target vascular family,
all diagnostic imaging for arteriography of the target vascular family, and all related
radiological supervision and interpretation. When diagnostic arteriogram (including imaging
and selective catheterization) confirms the need for angioplasty or stent placement, 61630
and 61635 are inclusive of these services. If angioplasty or stenting are not indicated, then
the appropriate codes for selective catheterization and imaging should be reported in lieu of
61630 and 61635)
61640 Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel
61641 each additional vessel in same vascular family
   (List separately in addition to primary procedure)
61642 each additional vessel in different vascular family
(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

61782 cranial, extradural

61783 spinal

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

(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

(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 10022, 20225, 62287, 62290, 62291)

62268   Percutaneous aspiration, spinal cord cyst or syrinx

62269   Biopsy of spinal cord, percutaneous needle

62270   Spinal puncture, lumbar, diagnostic

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

62273   Injection, epidural, of blood or clot patch

62280   Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions) with or without other therapeutic substance; subaracchnoid
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>62281</td>
<td>epidural, cervical or thoracic</td>
</tr>
<tr>
<td>62282</td>
<td>epidural, lumbar, sacral (caudal)</td>
</tr>
<tr>
<td>62284</td>
<td>Injection procedure for myelography and/or computed tomography, lumbar (other than C1-C2 and posterior fossa)</td>
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<tr>
<td>62287</td>
<td>Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar</td>
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<tr>
<td>62290</td>
<td>Injection procedure for discography, each level; lumbar cervical or thoracic</td>
</tr>
<tr>
<td>62291</td>
<td>Injection procedure for chemonucleolysis, including discography, intervertebral disk, single or multiple levels, lumbar</td>
</tr>
<tr>
<td>62294</td>
<td>Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal Myelography via lumbar injection, including radiological supervision and interpretation; cervical</td>
</tr>
<tr>
<td>62302</td>
<td>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</td>
</tr>
<tr>
<td>62303</td>
<td>thoracic</td>
</tr>
<tr>
<td>62304</td>
<td>lumbosacral</td>
</tr>
<tr>
<td>62305</td>
<td>2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical)</td>
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<tr>
<td>62320</td>
<td>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</td>
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<tr>
<td>62321</td>
<td>with imaging guidance (ie, fluoroscopy or CT)</td>
</tr>
<tr>
<td>62322</td>
<td>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</td>
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<tr>
<td>62323</td>
<td>with imaging guidance (ie, fluoroscopy or CT)</td>
</tr>
<tr>
<td>62324</td>
<td>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</td>
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<tr>
<td>62325</td>
<td>with imaging guidance (ie, fluoroscopy or CT)</td>
</tr>
<tr>
<td>62326</td>
<td>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</td>
</tr>
<tr>
<td>62327</td>
<td>with imaging guidance (ie, fluoroscopy or CT)</td>
</tr>
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</table>

**CATHETER IMPLANTATION**

62350 Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir infusion pump; without laminectomy
62351 with laminectomy
62355 Removal of previously implanted intrathecal or epidural catheter

**RESERVOIR/PUMP IMPLANTATION**

62360 Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
62361 nonprogrammable pump
62362 programmable pump, including preparation of pump, with or without programming
62365 Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion
62367 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill
62368 with reprogramming
62370 with reprogramming and refill (requiring skill of a physician or other qualified health care professional)
(Do not report 62367-62370 in conjunction with 95900, 95991)

**POSTERIOR EXTRADURAL LAMINOTOMY OR LAMINECTOMY FOR EXPLORATION/DECOMPRESSION OF NEURAL ELEMENTS OR EXCISION OF HERNIATED INTERVERTEBRAL DISKS**

(For bilateral procedure report 63020, 63030, 63035, 63040, 63042, 63043, 63044 with modifier 50)

63001 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), one or two vertebral segments; cervical
63003 thoracic
63005 lumbar, except for spondylolisthesis
63011 sacral
63012 Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63015 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical
63016 thoracic
63017 lumbar
63020 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63030 1 interspace, lumbar
63035 each additional interspace, cervical or lumbar
(List separately in addition to primary procedure)
(Use 63035 in conjunction with 63020-63030)
63040 Laminotomy (hemi-laminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; cervical

63042 Lumbar

63043 each additional cervical interspace
(List separately in addition to primary procedure)
(Use 63043 in conjunction with 63040)

63044 each additional lumbar interspace
(List separately in addition to primary procedure)
(Use 63044 in conjunction with code 63042)

63045 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; cervical

63046 Thoracic

63047 Lumbar

63048 each additional segment, cervical thoracic or lumbar
(List separately in addition to primary procedure)
(Use 63048 in conjunction with codes 63045-63047)

63050 Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments;

63051 with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)
(Do not report 63050 or 63051 in conjunction with 22600, 22614, 22840-22842, 63001, 63015, 63045, 63048, 63295 for the same vertebral segment(s))

**TRANSPECULAR OR COSTOVERTEBRAL APPROACH FOR POSTEROLATERAL EXTRADURAL EXPLORATION/DECOMPRESSION**

63055 Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disk), single segment; thoracic

63056 Lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disk)

63057 each additional segment, thoracic or lumbar
(List separately in addition to primary procedure)
(Use 63057 in conjunction with codes 63055, 63056)

63064 Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic; single segment

63066 each additional segment
(List separately in addition to primary procedure)
(Use 63066 in conjunction with code 63064)

**ANTERIOR OR ANTEROLATERAL APPROACH FOR EXTRADURAL EXPLORATION/DECOMPRESSION**
For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of spinal cord exploration/decompression operation, append modifier -62 to the procedure code (and any associated add-on codes for that procedure code as long as both surgeons continue to work together as primary surgeons). One surgeon should file one claim line representing the procedure performed by the two surgeons.

In this situation, modifier -62 may be appended to the definitive procedure code(s) 63075, 63077, 63081, 63085, 63087, 63090 and, as appropriate, to associated additional interspace add-on code(s) 63076, 63078 or additional segment add-on code(s) 63082, 63086, 63088, 63091 as long as both surgeons continue to work together as primary surgeons.

63075  Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
63076  cervical, each additional interspace
   (List separately in addition to primary procedure)
   (Use 63076 in conjunction with 63075)
63077  thoracic, single interspace
63078  thoracic, each additional interspace
   (List separately in addition to primary procedure)
   (Use 63078 in conjunction with 63077)
63081  Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082  cervical, each additional segment
   (List separately in addition to primary procedure)
   (Use 63082 in conjunction with 63081)
63085  Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment
63086  thoracic, each additional segment
   (List separately in addition to primary procedure)
   (Use 63086 in conjunction with 63085)
63087  Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment
63088  each additional segment
   (List separately in addition to primary procedure)
   (Use 63088 in conjunction with 63087)
63090  Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment
63091  each additional segment
   (List separately in addition to primary procedure)
   (Use 63091 in conjunction with 63090)
   (Procedures 63081-63091 include discectomy above and/or below vertebral segment)

**LATERAL EXTRACAVITARY APPROACH FOR EXTRADURAL EXPLORATION/DECOMPRESSION**
63101  Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment
63102  lumbar, single segment
63103  thoracic or lumbar, each additional segment
(List separately in addition to primary procedure)
(Use 63103 in conjunction with 63101 and 63102)

INCISION

63170  Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic or thoracolumbar
63172  Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid space
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
Physician - Procedure Codes, Section 5 - Surgery

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
63615 Stereotactic biopsy, aspiration, or excision of lesion spinal cord

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)
Repair of meningocele; less than 5 cm diameter
63702 Repair of meningocele; larger than 5 cm diameter
63704 Repair of myelomeningocele; less than 5 cm diameter
63706 Repair of myelomeningocele; larger than 5 cm diameter
63707 Repair of dural/cerebrospinal fluid leak, not requiring laminectomy
63709 Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy
63710 Dural graft, spinal

**SHUNT, SPINAL CSF**

63740 Creation of shunt, lumbar, subarachnoid- peritoneal, -pleural, or other; including laminectomy
63741 percutaneous, not requiring laminectomy
63744 Replacement, irrigation or revision of lumbosubarachnoid shunt
63746 Removal of entire lumbosubarachnoid shunt system without replacement

**EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM**

**INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC:**

**SOMATIC NERVES**

64400 Injection, anesthetic agent; trigeminal nerve, any division or branch
64402 facial nerve
64405 greater occipital nerve
64408 vagus nerve
64410 phrenic nerve
64413 cervical plexus
64415 brachial plexus, single
64416 brachial plexus, continuous infusion by catheter (including catheter placement)
64417 axillary nerve
64418 suprascapular nerve
64420 intercostal nerve, single
64421 intercostal nerves, multiple, regional block
64425 ilioinguinal, iliohypogastric nerves
64430 pudendal nerve
64435 paracervical (uterine) nerve
64445 sciatic nerve, single
64446 sciatic nerve, continuous infusion by catheter, (including catheter placement)
64447 femoral nerve, single
64448 femoral nerve, continuous infusion by catheter, (including catheter placement)
64449 lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)
64450 other peripheral nerve or branch
64455 Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)
(Do not report 64455 in conjunction with 64632)
64479  Injection(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
64508  carotid sinus (separate procedure)
64510  stellate ganglion (cervical sympathetic)
64517  superior hypogastric plexus
64520  lumbar or thoracic (paravertebral sympathetic)
64530  celiac plexus, with or without radiologic monitoring

NEUROSTIMULATORS (PERIPHERAL NERVE)

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

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
64565  neuromuscular
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
Physician - Procedure Codes, Section 5 - Surgery

64610  second and third division branches at foramen ovale under radiologic monitoring
64611  Chemodenervation of parotid and submandibular salivary glands, bilateral
64612  Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)
64615  muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
64616  neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)
64617  larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed
64620  Destruction by neurolytic agent; intercostal nerve
64630  Destruction by neurolytic agent; pudendal nerve
64632  plantar common digital nerve
(Do not report 64632 in conjunction with 64455)
64633  Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634  cervical or thoracic, each additional facet joint
(Use 64634 in conjunction with 64633)
64635  lumbar or sacral, single facet joint
64636  lumbar or sacral, each additional facet joint
(Use 64636 in conjunction with 64635)
(Do not report 64633-64636 in conjunction with 77003, 77012)
(For bilateral procedure, report 64633-64636 with modifier 50)
64640  other peripheral nerve or branch
64642  Chemodenervation of one extremity; 1-4 muscle(s)
64643  each additional extremity; 1-4 muscle(s) (List separately in addition to code for primary procedure)
64644  Chemodenervation of one extremity; 5 or more muscle(s)
64645  each additional extremity; 5 or more muscle(s) (List separately in addition to code for primary procedure)
64646  Chemodenervation of trunk muscle(s); 1-5 muscle(s)
64647  6 or more muscle(s)

SYMPATHETIC NERVES

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

NEUROPLASTY (EXPLORATION, NEUROLYSIS OR NERVE DECOMPRESSION)

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

TRANSECTION OR AVULSION

64732  Transection or avulsion of; supraorbital nerve
64734  infraorbital nerve
64736  mental nerve
64738  inferior alveolar nerve by osteotomy
64740  lingual nerve
64742  facial nerve, differential or complete
64744  greater occipital nerve
64746  phrenic nerve
64755  vagus nerve limited to proximal stomach (selective proximal vagotomy, proximal gastric
        vagotony, parietal cell vagotomy, supra- or highly selective vagotony)
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)
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(Use 64783 in conjunction with 64782)

64784 major peripheral nerve, except sciatic
64786 sciatic nerve
64787 Implantation of nerve end into bone or muscle
   (List separately in addition to neuroma excision)
   (Use 64787 in conjunction with 64774-64786)
64788 Excision of neurofibroma or neurolemmoma; cutaneous nerve
64790 major peripheral nerve
64792 extensive (including malignant type)
64795 Biopsy of nerve

SYMPATHETIC NERVES

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

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

NEURORRHAPHY

64831 Suture of digital nerve, hand or foot; one nerve
64832 each additional digital nerve
   (List separately in addition to primary procedure)
   (Use 64832 in conjunction with 64831)
64834 Suture of one nerve; hand or foot, common sensory nerve
64835 median motor thenar
64836 ulnar motor
64837 Suture of each additional nerve, hand or foot
   (List separately in addition to primary procedure)
   (Use 64837 in conjunction with 64834-64836)
64840 Suture of posterior tibial nerve
64856 Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64857 without transposition
64858 Suture of sciatic nerve
64859 Suture of each additional major peripheral nerve
   (List separately in addition to primary procedure)
   (Use 64859 in conjunction with 64856, 64857)
64861 Suture of; brachial plexus
64862 lumbar plexus
64864 Suture of facial nerve; extracranial
64865 infratemporal, with or without grafting
64866  Anastomosis; facial-spinal accessory
64868  facial-hypoglossal
64872  Suture of nerve; requiring secondary or delayed suture
         (List separately in addition to primary neurorrhaphy)
64874  requiring extensive mobilization, or transposition of nerve
         (List separately in addition to code for nerve suture)
64876  requiring shortening of bone of extremity
         (List separately in addition to code for nerve suture)
         (Use 64872, 64874, 64876 in conjunction with 64831-64865)

NEURORRHAPHY WITH NERVE GRAFT, VEIN GRAFT, OR CONDUIT

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

OTHER PROCEDURES

64999  Unlisted procedure, nervous system

EYE AND OCULAR ADNEXA

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

EYEBALL

REMOVAL OF EYE

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

SECONDARY IMPLANT(S) PROCEDURES

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

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

REMOVAL OF FOREIGN BODY

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

REPAIR OF LACERATION

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

ANTERIOR SEGMENT
CORNEA
EXCISION

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

REMOVAL OR DESTRUCTION

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

KERATOPLASTY

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

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

OTHER PROCEDURES

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

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

INCISION

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

REMOVAL

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

INTRODUCTION

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

ANTERIOR SCLERA

EXCISION

66130  Excision of lesion, sclera
66150  Fistulization of sclera for glaucoma; trephination with iridectomy
66155  thermocauterization with iridectomy
66160  sclerectomy with punch or scissors, with iridectomy
66170  trabeculectomy ab externo in absence of previous surgery
66172  trabeculectomy ab externo with scarring from previous ocular surgery or trauma
       (includes injection of antifibrotic agents)
66174  Transluminal dilation of aqueous outflow canal; without retention of device or stent
66175  with retention of device or stent
AQUEOUS SHUNT
66179  Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft
66180   with graft
66184  Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft
66185   with graft

REPAIR OR REVISION
66220  Repair of scleral staphyloma; without graft
66225   with graft
66250  Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure

IRIS, CILIARY BODY

INCISION
66500  Iridotomy by stab incision (separate procedure); except transfixion
66505   with transfixion as for iris bombe

EXCISION
66600  Iridectomy, with corneoscleral or corneal section; for removal of lesion
66605   with cyclectomy
66625   peripheral for glaucoma (separate procedure)
66630   sector for glaucoma (separate procedure)
66635   optical (separate procedure)

REPAIR
66680  Repair of iris, ciliary body (as for iridodialysis)
66682  Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture)

DESTRUCTION
66700  Ciliary body destruction; diathermy,
66710   cyclophotocoagulation, transscleral
66711   cyclophotocoagulation, endoscopic
   (Do not report 66711 in conjunction with 66990)
66720  cryotherapy
66740  cyclodialysis
66761  Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)
66762  Iridoplasty by photocoagulation (one or more sessions) (eg, for improvement of vision for widening of anterior chamber angle)
66770 Destruction of cyst or lesion iris or ciliary body (nonexcisional procedure)

**LENS**

**INCISION**

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

**REMOVAL**

Lateral canthotomy, iridectomy, iridotomy, anterior capsulotomy, posterior capsulotomy, the use of viscoelastic agents, enzymatic zonulysis, use of other pharmacologic agents, and subconjunctival or sub-tenon injections are included as part of the code for the extraction of lens.

66830 Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
66840 Removal of lens material; aspiration technique, one or more stages
66850 Phacofragmentation technique (mechanical or ultrasonic,)
(eg, phacoemulsification), with aspiration
66852 Pars plana approach, with or without vitrectomy
66920 Intracapsular
66930 Intracapsular, for dislocated lens
66940 Extracapsular (other than 66840, 66850, 66852)

**INTRAOCULAR LENS PROCEDURES**

66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage
66983 Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)
66985 Insertion of intraocular lens prosthesis (secondary implant) not associated with concurrent cataract removal
(For use of ophthalmic endoscope with 66985, use 66990)
66986 Exchange of intraocular lens
(For use of ophthalmic endoscope with 66986, use 66990)

**OTHER PROCEDURES**
66990 Use of ophthalmic endoscope
(List separately in addition to primary procedure)
(66990 may be used only with codes 65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041, 67042, 67043, 67113)
66999 Unlisted procedure, anterior segment, eye

POSTERIOR SEGMENT

VITREOUS

67005 Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal
67010 subtotal removal with mechanical vitrectomy
67015 Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)
67025 Injection of vitreous substitute, pars plana or limbal approach, (fluid-gas exchange), with or without aspiration (separate procedure)
67027 Implantation of intravitreal drug delivery system (eg, Ganciclovir implant), includes concomitant removal of vitreous
67028 Intravitreal injection of a pharmacologic agent (separate procedure)
67030 Discission of vitreous strands (without removal), pars plana approach
67031 Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)
67036 Vitrectomy, mechanical, pars plana approach;
67039 with focal endolaser 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)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>67311</td>
<td>Strabismus surgery, recession or resection procedure; one horizontal muscle</td>
</tr>
<tr>
<td>67312</td>
<td>two horizontal muscles</td>
</tr>
<tr>
<td>67314</td>
<td>one vertical muscle (excluding superior oblique)</td>
</tr>
<tr>
<td>67316</td>
<td>two or more vertical muscles (excluding superior oblique)</td>
</tr>
<tr>
<td>67318</td>
<td>Strabismus surgery, any procedure superior oblique muscle</td>
</tr>
<tr>
<td>67320</td>
<td>Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify)</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
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<tr>
<td>67331</td>
<td>Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular</td>
</tr>
<tr>
<td></td>
<td>muscles</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td>67332</td>
<td>Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus</td>
</tr>
<tr>
<td></td>
<td>or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy)</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td>67334</td>
<td>Strabismus surgery by posterior fixation suture technique, with or without muscle recession</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td>67335</td>
<td>Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s)</td>
</tr>
<tr>
<td></td>
<td>of suture(s)</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to code for specific strabismus surgery)</td>
</tr>
<tr>
<td>67340</td>
<td>Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s)</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td>67343</td>
<td>Release of extensive scar tissue without detaching extraocular muscle (separate procedure)</td>
</tr>
</tbody>
</table>
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)
67550  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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>67801</td>
<td>multiple, same lid</td>
</tr>
<tr>
<td>67805</td>
<td>multiple, different lids</td>
</tr>
<tr>
<td>67808</td>
<td>under general anesthesia and/or requiring hospitalization, single or multiple</td>
</tr>
<tr>
<td>67810</td>
<td>Incisional biopsy of eyelid skin including lid margin</td>
</tr>
<tr>
<td>67820</td>
<td>Correction of trichiasis; epilation, by forceps only</td>
</tr>
<tr>
<td>67825</td>
<td>epilation by other than forceps (eg, by electrosurgery, cryotherapy, laser surgery)</td>
</tr>
<tr>
<td>67830</td>
<td>incision of lid margin</td>
</tr>
<tr>
<td>67835</td>
<td>incision of lid margin, with free mucous membrane graft</td>
</tr>
<tr>
<td>67840</td>
<td>Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure</td>
</tr>
<tr>
<td>67850</td>
<td>Destruction of lesion of lid margin (up to 1 cm)</td>
</tr>
<tr>
<td></td>
<td><strong>TARSORRHAPHY</strong></td>
</tr>
<tr>
<td>67875</td>
<td>Temporary closure of eyelids by suture (eg, Frost suture)</td>
</tr>
<tr>
<td>67880</td>
<td>Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;</td>
</tr>
<tr>
<td>67882</td>
<td>with transposition of tarsal plate</td>
</tr>
<tr>
<td></td>
<td><strong>REPAIR (BROW PTOSIS, BLEPHAROPTOSIS, LID RETRACTION, ECTROPION, ENTROPION)</strong></td>
</tr>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
</tr>
<tr>
<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)</td>
</tr>
<tr>
<td>67902</td>
<td>frontalis muscle technique with autologous fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67903</td>
<td>(tarso) levator resection or advancement, internal approach</td>
</tr>
<tr>
<td>67904</td>
<td>(tarso) levator resection or advancement, external approach</td>
</tr>
<tr>
<td>67906</td>
<td>superior rectus technique with fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67908</td>
<td>conjunctivo-tarso-Muller’s muscle-levator resection (Fasanella-Servat type)</td>
</tr>
<tr>
<td>67909</td>
<td>Reduction of overcorrection of ptosis</td>
</tr>
<tr>
<td>67911</td>
<td>Correction of lid retraction</td>
</tr>
<tr>
<td>67912</td>
<td>Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)</td>
</tr>
<tr>
<td>67914</td>
<td>Repair of ectropion; suture</td>
</tr>
<tr>
<td>67915</td>
<td>thermocauterization</td>
</tr>
<tr>
<td>67916</td>
<td>excision tarsal wedge</td>
</tr>
<tr>
<td>67917</td>
<td>extensive (eg, tarsal strip operations)</td>
</tr>
<tr>
<td>67921</td>
<td>Repair of entropion; suture</td>
</tr>
<tr>
<td>67922</td>
<td>thermocauterization</td>
</tr>
<tr>
<td>67923</td>
<td>excision tarsal wedge</td>
</tr>
<tr>
<td>67924</td>
<td>extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)</td>
</tr>
<tr>
<td></td>
<td><strong>RECONSTRUCTION</strong></td>
</tr>
<tr>
<td></td>
<td>Codes for blepharoplasty involve more than skin (ie, involving lid margin, tarsus, and/or palpebral conjunctiva)</td>
</tr>
<tr>
<td>67930</td>
<td>Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva, direct closure; partial thickness</td>
</tr>
<tr>
<td>67935</td>
<td>full thickness</td>
</tr>
</tbody>
</table>
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  Conjunctivoorhinostomy (fistulization of conjunctiva to nasal cavity); without tube
68750   with insertion of tube or stent
68760  Closure of lacrimal punctum; by thermocauterization, ligation, or laser surgery
68761   by plug, each
68770  Closure of lacrimal fistula (separate procedure)

**PROBING AND/OR RELATED PROCEDURES**

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

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

68899  Unlisted procedure, lacrimal system

AUDITORY SYSTEM

EXTERNAL EAR

INCISION

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

EXCISION

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

REMOVAL

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

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

REPAIR

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

OTHER PROCEDURES

69399  Unlisted procedure, external ear

MIDDLE EAR
INCISION

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

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

EXCISION

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

REPAIR

69601 Revision mastoidectomy; resulting in complete mastoidectomy
69602 resulting in modified radical mastoidectomy
69603 resulting in radical mastoidectomy
69604 resulting in tympanoplasty
69605 with apicectomy
69610 Tympanic membrane repair, with or without site preparation or perforation for closure, with or without patch
69620 Myringoplasty (surgery confined to drumhead and donor area)
69631 Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
69632 with ossicular chain reconstruction, (eg, postfenestration)
69633 with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, (PORP), total ossicular replacement prosthesis, (TORP))
69635 Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction
69636 with ossicular chain reconstruction
69637 with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, (PORP), total ossicular replacement prosthesis, (TORP))
69641 Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction
69642 with ossicular chain reconstruction
69643 with intact or reconstructed wall, without ossicular chain reconstruction
69644 with intact or reconstructed canal wall, with ossicular chain reconstruction
69645 radical or complete, without ossicular chain reconstruction
69646 radical or complete, with ossicular chain reconstruction
69650 Stapes mobilization
69660 Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;
69661 with footplate drill out
69662 Revision of stapedectomy or stapedotomy
69666 Repair oval window fistula
69667 Repair round window fistula
69670 Mastoid obliteration (separate procedure)
69676 Tympanic neurectomy
(For bilateral procedure, use modifier -50)

OTHER PROCEDURES

69700 Closure postauricular fistula, mastoid (separate procedure)
69710 Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone
(Replacement procedure includes removal of old device)
69711 Removal or repair of electromagnetic bone conduction hearing device in temporal bone
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
69820  Fenestration semicircular canal
69840  Revision fenestration operation

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