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SURGERY SECTION

GENERAL INFORMATION AND RULES

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

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

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

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

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

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

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

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

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

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

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

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

13. **INFORMED CONSENT FOR STERILIZATION:**
When procedures are performed for the primary purpose of rendering an individual incapable of reproducing, and in all cases when procedures identified by MMIS codes 55250, 55450, 58565, 58600, 58605, 58611, 58615, 58670 and 58671 are performed, the following rules will apply:

a. The patient must be 21 years of age or older at the time to consent to sterilization.

b. The patient must have been informed of the risks and benefits of sterilization and have signed the mandated consent form, (DSS-3134) not less than 30 days nor more than 180 days prior to the performance of the procedure. In cases of premature delivery and emergency abdominal surgery, consent must have been given at least 72 hours prior to sterilization.

c. No bill will be processed for payment without a properly completed consent form. (Refer to Billing Section for completion instructions).

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

14. **RECEIPT OF HYSTERECTOMY INFORMATION:**
Hysterectomies must not be performed for the purpose of sterilization. When hysterectomy procedures are performed and in all cases when procedures identified by MMIS codes 51925, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58951, 58953, 58954, 58956, 59135, or 59525 are billed, a properly completed "Hysterectomy Receipt of Information Form" must be attached to the bill
for payment. No bill will be processed without a properly completed "Hysterectomy Receipt of Information Form", (DSS-3113).

15. **BILLING GUIDELINES:**
   For additional general billing guidelines see the current CTP 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/](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 or Nurse Practitioner Services for Assist at Surgery: When the physician requests that a Physician Assistant or Nurse Practitioner assist at surgery, **or requests a licensed midwife to assist for a Cesarean section**, in lieu of another physician, Modifier -AS should be added to the appropriate code describing the procedure. One claim is to be filed. (Reimbursement will not exceed 120% of the maximum Fee Schedule amount).

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

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

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

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

11400 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401 excised diameter 0.6 to 1.0 cm
11402 excised diameter 1.1 to 2.0 cm
11403 excised diameter 2.1 to 3.0 cm
11404 excised diameter 3.1 to 4.0 cm
11406 excised diameter over 4.0 cm
11420 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421 excised diameter 0.6 to 1.0 cm
11422 excised diameter 1.1 to 2.0 cm
11423 excised diameter 2.1 to 3.0 cm
11424 excised diameter 3.1 to 4.0 cm
11426 excised diameter over 4.0 cm
11440 Excision, other benign lesion including margins, (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441 excised diameter 0.6 to 1.0 cm
11442 excised diameter 1.1 to 2.0 cm
11443 excised diameter 2.1 to 3.0 cm
11444 excised diameter 3.1 to 4.0 cm
11446  excised diameter over 4.0 cm
11450  Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair
11451  with complex repair
11462  Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair
11463  with complex repair
11470  Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal or umbilical; with simple or intermediate repair
11471  with complex repair
   (For bilateral procedure, add modifier 50)

EXCISION - MALIGNANT LESIONS

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

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

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

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

To report a re-excision procedure performed to widen margins at a subsequent operative session, see codes 11600-11646, as appropriate.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11600</td>
<td>Excision, malignant lesion including margins, trunk, arms or legs; excised</td>
</tr>
<tr>
<td></td>
<td>diameter 0.5 cm or less</td>
</tr>
<tr>
<td>11601</td>
<td>excised diameter 0.6 to 1.0 cm</td>
</tr>
<tr>
<td>11602</td>
<td>excised diameter 1.1 to 2.0 cm</td>
</tr>
<tr>
<td>11603</td>
<td>excised diameter 2.1 to 3.0 cm</td>
</tr>
<tr>
<td>11604</td>
<td>excised diameter 3.1 to 4.0 cm</td>
</tr>
<tr>
<td>11606</td>
<td>excised diameter over 4.0 cm</td>
</tr>
<tr>
<td>11620</td>
<td>Excision, malignant lesion including margins, scalp, neck, hands, feet,</td>
</tr>
<tr>
<td></td>
<td>genitalia; excised diameter 0.5 cm or less</td>
</tr>
<tr>
<td>11621</td>
<td>excised diameter 0.6 to 1.0 cm</td>
</tr>
<tr>
<td>11622</td>
<td>excised diameter 1.1 to 2.0 cm</td>
</tr>
<tr>
<td>11623</td>
<td>excised diameter 2.1 to 3.0 cm</td>
</tr>
<tr>
<td>11624</td>
<td>excised diameter 3.1 to 4.0 cm</td>
</tr>
<tr>
<td>11626</td>
<td>excised diameter over 4.0 cm</td>
</tr>
<tr>
<td>11640</td>
<td>Excision, malignant lesion including margins, face, ears, eyelids, nose,</td>
</tr>
<tr>
<td></td>
<td>lips; excised diameter 0.5 cm or less</td>
</tr>
<tr>
<td>11641</td>
<td>excised diameter 0.6 to 1.0 cm</td>
</tr>
<tr>
<td>11642</td>
<td>excised diameter 1.1 to 2.0 cm</td>
</tr>
<tr>
<td>11643</td>
<td>excised diameter 2.1 to 3.0 cm</td>
</tr>
<tr>
<td>11644</td>
<td>excised diameter 3.1 to 4.0 cm</td>
</tr>
<tr>
<td>11646</td>
<td>excised diameter over 4.0 cm</td>
</tr>
</tbody>
</table>

**NAILS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11720</td>
<td>Debridement of nail(s) by any method(s); one to five</td>
</tr>
<tr>
<td>11721</td>
<td>six or more</td>
</tr>
<tr>
<td>11730</td>
<td>Avulsion of nail plate, partial or complete, simple; single</td>
</tr>
<tr>
<td>11732</td>
<td>each additional nail plate</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 11732 in conjunction with 11730)</td>
</tr>
<tr>
<td>11740</td>
<td>Evacuation of subungual hematoma</td>
</tr>
<tr>
<td>11750</td>
<td>Excision of nail and nail matrix, partial or complete, (eg, ingrown or</td>
</tr>
<tr>
<td></td>
<td>deformed nail) for permanent removal;</td>
</tr>
<tr>
<td>11752</td>
<td>with amputation of tuft of distal phalanx</td>
</tr>
<tr>
<td>11755</td>
<td>Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and</td>
</tr>
<tr>
<td></td>
<td>lateral nail folds) (separate procedure)</td>
</tr>
<tr>
<td>11760</td>
<td>Repair of nail bed</td>
</tr>
<tr>
<td>11762</td>
<td>Reconstruction of nail bed with graft</td>
</tr>
<tr>
<td>11765</td>
<td>Wedge excision of skin of nail fold (eg, for ingrown toenail)</td>
</tr>
</tbody>
</table>

**PILONAL CYST**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11770</td>
<td>Excision of pilonidal cyst or sinus; simple</td>
</tr>
<tr>
<td>11771</td>
<td>extensive</td>
</tr>
</tbody>
</table>
Physician - Procedure Codes, Section 5 - Surgery

11772 complicated

INTRODUCTION

11900 Injection, intrallesional; 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 (Report required)
(List separately in addition to primary procedure)
(Use 11922 in conjunction with 11921)
11950 Subcutaneous injection of filling material (eg, collagen); 1 cc or less (Report required)
11951 1.1 to 5 cc (Report required)
11952 5.1 to 10 cc (Report required)
11954 over 10 cc (Report required)
11960 Insertion of tissue expander(s) for other than breast, including subsequent expansion
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**

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

**REPAIR-INTERMEDIATE**

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

12056  20.1 cm to 30.0 cm
12057  over 30.0 cm

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 AUTOGRAFT

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

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

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

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

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

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

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

15116 each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof  
(List separately in addition to primary procedure)
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)
    each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
    (List separately in addition to primary procedure)
    (Use 15121 in conjunction with 15120)

15130  Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children
    each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
    (List separately in addition to primary procedure)
    (Use 15131 in conjunction with 15130)

15135  Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children
    each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
    (List separately in addition to primary procedure)
    (Use 15136 in conjunction with 15135)

15150  Tissue cultured skin autograft, trunk, arms, legs; first 25 sq cm or less
    additional 1 sq cm to 75 sq cm
    (List separately in addition to primary procedure)
    (Do not report 15151 more than once per session)
    (Use 15151 in conjunction with 15150)

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

15155  Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less
    additional 1 sq cm to 75 sq cm
    (List separately in addition to primary procedure)
    (Do not report 15156 more than once per session)
    (Use 15156 in conjunction with 15155)

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

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

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

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

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 each additional 1% of body area of infants and children, or part thereof

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

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 (Report required)
15776 more than 15 punch grafts (Report required)
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) (Report required)
15786 Abrasion; single lesion (eg, keratosis, scar)
15787 each additional four lesions or less
   (List separately in addition to primary procedure)
   (Use 15787 in conjunction with 15786)
15788 Chemical peel, facial; epidermal
15789 dermal
15792 Chemical peel, nonfacial; epidermal
15793 dermal
15819 Cervicoplasty
15820 Blepharoplasty, lower eyelid;
15821 with extensive herniated fat pad
15822 Blepharoplasty, upper eyelid;
15823 with excessive skin weighting down lid
   (For bilateral blepharoplasty, add modifier 50)
15824 Rhytidectomy; forehead
   (For 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 (Report required)
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) (Report required)
(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 (Report required)
15877 trunk (Report required)
15878 upper extremity (Report required)
15879 lower extremity (Report required)

PRESSURE ULCERS (DECUBITIS ULCERS)

15920 Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture
15922 with flap closure
15931 Excision, sacral pressure ulcer, with primary suture;
15933 with ostectomy
15934 Excision, sacral pressure ulcer, with skin flap closure
15935 with ostectomy
15936 Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;
15937 with ostectomy 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 (Report required)

17003 second through 14 lesions, each (Report required) (List separately in addition to code for first lesion) (Use 17003 in conjunction with 17000) (Do not report 17004 in addition to 17000 – 17003)

17004 15 or more lesions (Report required) (Do not report 17004 in addition to 17000 – 17003)

17106 Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm

17107 10.0 - 50.0 sq cm

17108 over 50.0 sq cm

17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions

17111 15 or more lesions

17250 Chemical cauterization of granulation tissue (proud flesh, sinus or fistula) (17250 is not to be used with excision/removal codes for the same lesions)

**DESTRUCTION, MALIGNANT LESIONS, ANY METHOD**

17260 Destruction, malignant lesion, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less

17261 lesion diameter 0.6 to 1.0 cm

17262 lesion diameter 1.1 to 2.0 cm

17263 lesion diameter 2.1 to 3.0 cm

17264 lesion diameter 3.1 to 4.0 cm (Report required)

17266 lesion diameter over 4.0 cm (Report required)

17270 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

17271 lesion diameter 0.6 to 1.0 cm

17272 lesion diameter 1.1 to 2.0 cm

17273 lesion diameter 2.1 to 3.0 cm

17274 lesion diameter 3.1 to 4.0 cm

17276 lesion diameter over 4.0 cm
17280 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettlement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
17281 lesion diameter 0.6 to 1.0 cm
17282 lesion diameter 1.1 to 2.0 cm
17283 lesion diameter 2.1 to 3.0 cm (Report required)
17284 lesion diameter 3.1 to 4.0 cm (Report required)
17286 lesion diameter over 4.0 cm (Report required)

**MOHS’ MICROGRAPHIC SURGERY**

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

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

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

**OTHER PROCEDURES**

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

**BREAST**

**INCISION**

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

**EXCISION**

(To report bilateral procedures, use modifier -50)

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

Breast biopsies are reported using codes 19100-19103. The open excision of breast lesions (eg, lesions of the breast ducts, cysts, benign or malignant tumors), without specific attention to adequate surgical margins, with or without the preoperative placement of radiological markers, is reported using codes 19110-19126. Partial mastectomy procedures (eg, lumpectomy, tylectomy, quadrantectomy, or segmentectomy) describe open excisions of breast tissue with specific attention to adequate surgical margins.
Partial mastectomy procedures are reported using codes 19301 or 19302 as appropriate. Documentation for partial mastectomy procedures includes attention to the removal of adequate surgical margins surrounding the breast mass or lesion.

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

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

19081   Biopsy, breast, with placement of breast localization devices(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance
19082 each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)
19083 Biopsy, breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance
19084 each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)
19085 Biopsy, breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance
19086 each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)
19100 Biopsy of breast; percutaneous, needle core, not using needle guidance (separate procedure)
19101 open, incisional
19105 Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma (Do not report 19105 in conjunction with 76940, 76942)
19110 Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct
19112 Excision of lactiferous duct fistula
19120 Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, one or more lesions
19125 Excision of breast lesion identified by pre-operative placement of radiological marker, open; single lesion
19126  each additional lesion separately identified by a preoperative radiological maker  
(List separately in addition to primary procedure)  
(Use 19126 in conjunction with code 19125)  
19260  Excision of chest wall tumor including ribs  
19271  Excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy  
19272  with mediastinal lymphadenectomy  
(Do not report 19260, 19271, 19272 in conjunction with 32100, 32503, 32504, 32551, 32554, 32555)  

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

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

**OTHER PROCEDURES**

19499  Unlisted procedure, breast

**MUSCULOSKELETAL SYSTEM**

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

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

**DEFINITIONS:**

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

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

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

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

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

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

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

Skin traction is the application of a force (longitudinal) to a limb using felt or strapping applied directly to skin only.
External fixation is the usage of skeletal pins plus an attaching mechanism/device used for temporary or definitive treatment of acute or chronic bony deformity.

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

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

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

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

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

GENERAL INCISION

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

INTRODUCTION OR REMOVAL

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

REPLANTATION

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

GRAFTS (OR IMPLANTS)

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20900</td>
<td>Bone graft, any donor area; minor or small (eg, dowel or button)</td>
</tr>
<tr>
<td>20902</td>
<td>major or large</td>
</tr>
<tr>
<td>20910</td>
<td>Cartilage graft; costochondral</td>
</tr>
<tr>
<td>20912</td>
<td>nasal septum</td>
</tr>
<tr>
<td>20920</td>
<td>Fascia lata graft; by stripper</td>
</tr>
<tr>
<td>20922</td>
<td>by incision and area exposure, complex or sheet</td>
</tr>
<tr>
<td>20924</td>
<td>Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)</td>
</tr>
<tr>
<td>20926</td>
<td>Tissue grafts, other (eg, paratenon, fat, dermis)</td>
</tr>
<tr>
<td>20931</td>
<td>Allograft, structural, for spine surgery only</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 20931 in conjunction with 22319, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812)</td>
</tr>
<tr>
<td>20937</td>
<td>morselized (through separate skin or fascial incision)</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 20937 in conjunction with 22319, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812)</td>
</tr>
<tr>
<td>20938</td>
<td>structural, bicortical or tricortical (through separate skin or fascial incision)</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 20938 in conjunction with 22319, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812)</td>
</tr>
</tbody>
</table>

(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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20950</td>
<td>Monitoring of interstitial fluid pressure (includes insertion of device eg, wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome</td>
</tr>
<tr>
<td>20955</td>
<td>Bone graft with microvascular anastomosis; fibula</td>
</tr>
<tr>
<td>20956</td>
<td>iliac crest</td>
</tr>
<tr>
<td>20957</td>
<td>metatarsal</td>
</tr>
<tr>
<td>20962</td>
<td>other than fibula, iliac crest, or metatarsal</td>
</tr>
<tr>
<td>20969</td>
<td>Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe</td>
</tr>
<tr>
<td>20970</td>
<td>iliac crest (Report required)</td>
</tr>
<tr>
<td>20972</td>
<td>metatarsal (Report required)</td>
</tr>
<tr>
<td>20973</td>
<td>great toe with web space (Report required)</td>
</tr>
<tr>
<td>20974#</td>
<td>Electrical stimulation to aid bone healing; noninvasive (nonoperative)</td>
</tr>
<tr>
<td>20975</td>
<td>invasive (operative)</td>
</tr>
</tbody>
</table>
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 (Report required)

20999 Unlisted procedure, musculoskeletal system, general

**HEAD**

Skull, facial bones and temporomandibular joint.

**INCISION**

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

**EXCISION**

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

MANIPULATION

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

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
         (Report required)
21077    orbital prosthesis (Report required)
21079    interim obturator prosthesis (Report required)
21080    definitive obturator prosthesis (Report required)
21081    mandibular resection prosthesis (Report required)
21082    palatal augmentation prosthesis (Report required)
21083    palatal lift prosthesis (Report required)
21084    speech aid prosthesis (Report required)
21085    oral surgical splint
21086    auricular prosthesis (Report required)
21087    nasal prosthesis (Report required)
21088    facial prosthesis
21089    Unlisted maxillofacial prosthetic procedure

INTRODUCTION OR REMOVAL

21100    Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure) (Report required)
21110 Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
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) *(Report required)*
21125 Augmentation, mandibular body or angle; prosthetic material
21127 with bone graft, onlay or interpositional (includes obtaining autograft)
21137 Reduction forehead; contouring only *(Report required)*
21138 contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139 contouring and setback of anterior frontal sinus wall *(Report required)*
21141 Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
21142 two pieces, segment movement in any direction, without bone graft
21143 three or more pieces, segment movement in any direction, without bone graft
21145 single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146 two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
21147 three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
21150 Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome) *(Report required)*
21151 any direction, requiring bone grafts (includes obtaining autografts) *(Report required)*
21154 Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I
21155 with LeFort I
21159 Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I *(Report required)*
21160 with LeFort I *(Report required)*
21172 Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175  Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)

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

21180  with autograft (includes obtaining grafts)

21181  Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial

21182  Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra¬ and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm (Report required)

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

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

21188  Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)

21193  Reconstruction of mandibular rami, horizontal, vertical, "C", or "L" osteotomy; without bone graft

21194  with bone graft (includes obtaining graft) (Report required)

21195  Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation (Report required)

21196  with internal rigid fixation

21198  Osteotomy, mandible, segmental;

21199  with genioglossus advancement

21206  Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)

21208  Osteoplasty, facial bones; augmentation (autograft, allograft or prosthetic implant)

21209  reduction

21210  Graft, bone; nasal, maxillary and malar areas (includes obtaining graft)

21215  mandible (includes obtaining graft)

21230  Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)

21235  ear cartilage, autograft, to nose or ear (includes obtaining graft)

21240  Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)

21242  Arthroplasty, temporomandibular joint, with allograft

21243  Arthroplasty, temporomandibular joint, with prosthetic joint replacement (Report required)

21244  Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)

21245  Reconstruction of mandible or maxilla, subperiosteal implant; partial

21246  complete
21247  Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
21248  Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
21249  complete (Report required)
21255  Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256  Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)
21260  Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261  combined intra- and extracranial approach (Report required)
21263  with forehead advancement
21267  Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268  combined intra- and extracranial approach (Report required)
21270  Malar augmentation, prosthetic material
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 (Report required)
21296  intraoral approach (Report required)

OTHER PROCEDURES

21299  Unlisted craniofacial and maxillofacial procedure

FRACURE 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)
21349  Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation
21350  Open treatment of depressed zygomatic arch fracture (eg, Gilles approach)
21351  Open treatment of depressed malar fracture, including zygomatic arch and malar tripod
21352  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
21353  with bone grafting (includes obtaining graft)
21354  Open treatment of orbital floor blowout fracture; transantral approach (Caldwell Luc type operations)
21355  periorbital approach
21356  combined approach
21357  periorbital approach, with alloplastic or other implant
21358  periorbital approach with bone graft (includes obtaining graft)
21359  Closed treatment of fracture of orbit, except blowout; without manipulation
21360  with manipulation
21361  Open treatment of fracture of orbit except blowout; without implant
21362  with implant
21363  with bone grafting (includes obtaining graft)
21364  Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint
21365  Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches
21366  Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint
21367  Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation
21368  complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches
21369  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) (Report required)
21440  Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21445  Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21450  Closed treatment of mandibular fracture; without manipulation
21451  with manipulation
21452  Percutaneous treatment of mandibular fracture, with external fixation
21453  Closed treatment of mandibular fracture with interdental fixation
21454  Open treatment of mandibular fracture with external fixation
21461  Open treatment of mandibular fracture; without interdental fixation
21462  with interdental fixation
21465  Open treatment of mandibular condylar fracture
21470  Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints
21480  Closed treatment of temporomandibular dislocation, initial or subsequent
21485  complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent (Report required)
21490  Open treatment of temporomandibular dislocation
21495  Open treatment of hyoid fracture (Report required)

OTHER PROCEDURES
21497  Interdental wiring, for condition other than fracture (Report required)
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 Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; 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 or greater
21558 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 (Report required)
21750 Closure of median sternotomy separation with or without debridement (separate procedure)

FRACTURE AND/OR DISLOCATION

21805 Open treatment of rib fracture without fixation, each (Report required)
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  Biopsy, soft tissue of back or flank; 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 20931-20938. Do not append modifier –62 to bone graft codes 20900 – 20938. Example: Posterior arthrodesis of L5-S1 for degenerative disc disease utilizing morselized autogenous iliac bone graft harvested through a separate fascial incision. Report as 22612 and 20937.

Within the SPINE section, instrumentation is reported separately and in addition to arthrodesis. To report instrumentation procedures performed with definitive vertebral procedure(s), see codes 22840-22855. Instrumentation procedure codes 22840-22848 and 22851 are reported in addition to the definitive procedure(s). The modifier –62 may not be appended to the definitive add-on spinal instrumentation procedure code(s) 22840 – 22848 and 22850-22852. Example: Posterior arthrodesis of L4-S1, utilizing morselized autogenous iliac bone graft harvested through separate fascial incision, and pedicle screw fixation. Report as 22612, 22614, 22842 and 20937.

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

**INCISION**

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

**EXCISION**

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

22100 Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical
22101 thoracic
22102 lumbar
22103 each additional segment
   (List separately in addition to primary procedure)
   (Use 22103 in conjunction with codes 22100, 22101, 22102)

22110 Partial excision of vertebral body for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical
22112 thoracic
22114 lumbar
22116 each additional vertebral segment
   (List separately in addition to primary procedure)
   (Use 22116 only for codes 22110, 22112, 22114)

**OSTEOTOMY**

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

**22206** Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic  
(Do not report 22206 in conjunction with 22207)

**22207** lumbar  
(Do not report 22207 in conjunction with 22206)

**22208** each additional vertebral segment  
(List separately in addition to primary procedure)  
(Use 22208 in conjunction with 22206, 22207)  
(Do not report 22206, 22207, 22208 in conjunction with 22210-22226, 22830, 63001-63048, 63055-63066, 63075-63091, 63101-63103, when performed at the same level)

22210 Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; cervical

**22212** thoracic

**22214** lumbar

22216 each additional segment  
(List separately in addition to primary procedure)  
(Use 22216 in conjunction with 22210, 22212, 22214)

22220 Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical

**22222** thoracic

**22224** lumbar

22226 each additional segment  
(List separately in addition to primary procedure)  
(Use 22226 only for codes 22220, 22222, 22224)

**FRACTURE AND/OR DISLOCATION**

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

**22305** Closed treatment of vertebral process fracture(s)

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

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

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 and 22851 are reported in addition to the definitive procedure(s). Do not append modifier –62 to spinal instrumentation codes 22840-22848 and 22850-22852.

To report bone graft procedures, see codes 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, 22851 are reported in conjunction with code(s) for the definitive procedure(s). Code 22849 should not be reported with 22850, 22852, and 22855 at the same spinal levels.
22840 Posterior non-segmental instrumentation (eg, Harrington Rod Technique), pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation
(List separately in addition to primary procedure)
(Use 22840 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

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)
(Use 22842 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

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

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

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

22846  4 to 7 vertebral segments
(Use 22846 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)
22847 8 or more vertebral segments
(Use 22847 in conjunction with 22100-22102, 22110-22114, 22206-22208, 22210-22214, 22220-22224, 22305-22327, 22532-22533, 22548-22558, 22590-22612, 22630, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102, 63170-63290, 63300-63307)

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

22849 Reinsertion of spinal fixation device

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

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

22852 Removal of posterior segmental instrumentation

22855 Removal of anterior instrumentation

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

22859 second level, cervical (List separately in addition to code for primary procedure)

22858 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar
(Do not report 22857 in conjunction with 22558, 22845, 22851, 49010 when performed at the same level)

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

22862 lumbar
(Do not report 22862 in conjunction with 22558, 22845, 22851, 22865, 49010 when performed at the same level)
22864  Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
(Do not report 22864 in conjunction with 22861)
22865  Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace, lumbar
(Do not report 22865 in conjunction with 49010)
(22857-22865 include fluoroscopy when performed)

OTHER PROCEDURES

22899  Unlisted procedure, spine

ABDOMEN

EXCISION

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

OTHER PROCEDURES

22999  Unlisted procedure, abdomen, musculoskeletal system

SHOULDER

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

INCISION

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<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>23336</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>23411</td>
<td>chronic</td>
</tr>
<tr>
<td>23415</td>
<td>Coracoacromial ligament release, with or without acromioplasty</td>
</tr>
<tr>
<td>23420</td>
<td>Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes</td>
</tr>
<tr>
<td></td>
<td>acromioplasty)</td>
</tr>
<tr>
<td>23430</td>
<td>Tenodesis of long tendon of biceps</td>
</tr>
<tr>
<td>23440</td>
<td>Resection or transplantation of long tendon of biceps</td>
</tr>
<tr>
<td>23450</td>
<td>Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation</td>
</tr>
<tr>
<td>23455</td>
<td>with labral repair (eg, Bankart procedure)</td>
</tr>
<tr>
<td>23460</td>
<td>Capsulorrhaphy, anterior, any type; with bone block</td>
</tr>
<tr>
<td>23462</td>
<td>with coracoid process transfer</td>
</tr>
<tr>
<td>23465</td>
<td>Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block</td>
</tr>
<tr>
<td>23466</td>
<td>Capsulorrhaphy, glenohumeral joint, any type multi-directional instability</td>
</tr>
<tr>
<td>23470</td>
<td>Arthroplasty, glenohumeral joint; hemiarthroplasty</td>
</tr>
<tr>
<td>23472</td>
<td>total shoulder (glenoid and proximal humeral replacement (eg, total</td>
</tr>
<tr>
<td></td>
<td>shoulder)</td>
</tr>
<tr>
<td>23473</td>
<td>Revision of total shoulder arthroplasty, including allograft when performed;</td>
</tr>
<tr>
<td></td>
<td>humeral or glenoid component</td>
</tr>
<tr>
<td>23474</td>
<td>humeral and glenoid component</td>
</tr>
<tr>
<td>23480</td>
<td>Osteotomy, clavicle, with or without internal fixation;</td>
</tr>
<tr>
<td>23485</td>
<td>with bone graft for nonunion or malunion (includes obtaining graft and/or</td>
</tr>
<tr>
<td></td>
<td>necessary fixation)</td>
</tr>
<tr>
<td>23490</td>
<td>Prophylactic treatment (nailing, pinning, plating, or wiring) with or without</td>
</tr>
<tr>
<td></td>
<td>methylmethacrylate; clavicle</td>
</tr>
<tr>
<td>23491</td>
<td>proximal humerus</td>
</tr>
</tbody>
</table>
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; (Report required)  
23802  with autogenous graft (includes obtaining graft)

**AMPUTATION**

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

**OTHER PROCEDURES**

23929  Unlisted procedure, shoulder

**HUMERUS (UPPER ARM) AND ELBOW**

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

**INCISION**

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

**INTRODUCTION OR REMOVAL**

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

**REPAIR, REVISION AND/OR RECONSTRUCTION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24300</td>
<td>Manipulation, elbow, under anesthesia</td>
</tr>
</tbody>
</table>
24301 Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)
24305 Tendon lengthening, upper arm or elbow, each tendon
24310 Tenotomy, open, elbow to shoulder, each tendon
24320 Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)
24330 Flexor-plasty, elbow, (eg, Steindler type advancement); with extensor advancement
24332 Tenolysis, triceps
24340 Tenodesis of biceps tendon at elbow (separate procedure)
24341 Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)
24342 Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
24343 Repair lateral collateral ligament, elbow, with local tissue
24344 Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24345 Repair medial collateral ligament, elbow, with local tissue
24346 Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24357 Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous
24358 Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open
24359 Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment
24360 Arthroplasty, elbow; with membrane (eg, fascial)
24361 with distal humeral prosthetic replacement
24362 with implant and fascia lata ligament reconstruction
24363 with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)
24365 Arthroplasty, radial head;
24366 with implant
24370 Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component
24371 humeral and ulnar component
24400 Osteotomy, humerus, with or without internal fixation
24410 Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)
24420 Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876)
24430 Repair of nonunion or malunion, humerus; without graft (eg, compression technique, etc)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24435</td>
<td>24470 Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus)</td>
</tr>
<tr>
<td></td>
<td>with iliac or other autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>24495</td>
<td>24498 Decompression fasciotomy, forearm, with brachial artery exploration</td>
</tr>
<tr>
<td></td>
<td>Prophylactic treatment (nailing, pinning, plating or wiring) with or without</td>
</tr>
<tr>
<td></td>
<td>methylmethacrylate, humeral shaft</td>
</tr>
<tr>
<td></td>
<td><strong>FRACTURE AND/OR DISLOCATION</strong></td>
</tr>
<tr>
<td>24500</td>
<td>Closed treatment of humeral shaft fracture; without manipulation</td>
</tr>
<tr>
<td>24505</td>
<td>with manipulation, with or without skeletal traction</td>
</tr>
<tr>
<td>24515</td>
<td>Open treatment of humeral shaft fracture with plate/screws, with or without</td>
</tr>
<tr>
<td></td>
<td>cerclage</td>
</tr>
<tr>
<td>24516</td>
<td>Treatment of humeral shaft fracture, with insertion of intramedullary implant,</td>
</tr>
<tr>
<td></td>
<td>with or without cerclage and/or locking screws</td>
</tr>
<tr>
<td>24530</td>
<td>Closed treatment of supracondylar or transcondylar humeral fracture, with or</td>
</tr>
<tr>
<td></td>
<td>without intercondylar extension; without manipulation</td>
</tr>
<tr>
<td>24535</td>
<td>with manipulation, with or without skin or skeletal traction</td>
</tr>
<tr>
<td>24538</td>
<td>Percutaneous skeletal fixation of supracondylar or transcondylar humeral</td>
</tr>
<tr>
<td></td>
<td>fracture, with or without intercondylar extension</td>
</tr>
<tr>
<td>24545</td>
<td>Open treatment of humeral supracondylar or transcondylar fracture, includes</td>
</tr>
<tr>
<td></td>
<td>internal fixation, when performed; without intercondylar extension</td>
</tr>
<tr>
<td>24546</td>
<td>with intercondylar extension</td>
</tr>
<tr>
<td>24550</td>
<td>Closed treatment of humeral epicondylar fracture, medial or lateral; without</td>
</tr>
<tr>
<td></td>
<td>manipulation</td>
</tr>
<tr>
<td>24565</td>
<td>with manipulation</td>
</tr>
<tr>
<td>24566</td>
<td>Percutaneous skeletal fixation of humeral epicondylar fracture, medial or</td>
</tr>
<tr>
<td></td>
<td>lateral, with manipulation</td>
</tr>
<tr>
<td>24575</td>
<td>Open treatment of humeral epicondylar fracture, medial or lateral, includes</td>
</tr>
<tr>
<td></td>
<td>internal fixation, when performed</td>
</tr>
<tr>
<td>24576</td>
<td>Closed treatment of humeral condylar fracture, medial or lateral; without</td>
</tr>
<tr>
<td></td>
<td>manipulation</td>
</tr>
<tr>
<td>24577</td>
<td>with manipulation</td>
</tr>
<tr>
<td>24579</td>
<td>Open treatment of humeral condylar fracture, medial or lateral, includes</td>
</tr>
<tr>
<td></td>
<td>internal fixation, when performed</td>
</tr>
<tr>
<td>24582</td>
<td>Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral,</td>
</tr>
<tr>
<td></td>
<td>with manipulation</td>
</tr>
<tr>
<td>24586</td>
<td>Open treatment of periarticular fracture and/or dislocation of the elbow (fracture</td>
</tr>
<tr>
<td></td>
<td>distal humerus and proximal ulna and/or proximal radius);</td>
</tr>
<tr>
<td>24587</td>
<td>with implant arthroplasty</td>
</tr>
<tr>
<td></td>
<td>(See also 24361)</td>
</tr>
<tr>
<td>24600</td>
<td>Treatment of closed elbow dislocation; without anesthesia</td>
</tr>
<tr>
<td>24605</td>
<td>requiring anesthesia</td>
</tr>
<tr>
<td>24615</td>
<td>Open treatment of acute or chronic elbow dislocation</td>
</tr>
</tbody>
</table>
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)

AMPLATION

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 (Report required)
24940    Cineplasty, upper extremity, complete procedure

OTHER PROCEDURES

24999    Unlisted procedure, humerus or elbow

FOREARM AND WRIST

Radius, ulna, carpal bones and joints.

INCISION

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

**EXCISION**

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

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

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

FRACTURE AND/OR DISLOCATION

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

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

ARTHRODESIS

25800  Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)
25805  with sliding graft
25810  with iliac or other autograft (includes obtaining graft)
25820  Arthrodesis, wrist; limited, without bone graft (eg, intercarpal or radiocarpal)
25825  with autograft (includes obtaining graft)
25830  Arthrodesis with distal radioulnar joint and segmental resection of ulna, with or without bone graft (eg, Sauve-Kapandji procedure)
AMPUTATION
25900  Amputation, forearm, through radius and ulna;
25905  open, circular (guillotine)
25907  secondary closure or scar revision
25909  re-amputation
25915  Krukenberg procedure
25920  Disarticulation through wrist;
25922  secondary closure or scar revision
25924  re-amputation
25927  Transmetacarpal amputation;
25929  secondary closure or scar revision
25931  re-amputation

OTHER PROCEDURES
25999  Unlisted procedure, forearm or wrist

HAND AND FINGERS

INCISION
26010  Drainage of finger abscess; simple
26011  complicated (eg, felon)
26020  Drainage of tendon sheath, one digit and/or palm, each
26025  Drainage of palmar bursa; single bursa
26030  multiple bursa
26034  Incision, bone cortex, hand or finger (eg, osteomyelitis or bone abscess)
26035  Decompression fingers and/or hand, injection injury (eg, grease gun)
   (Report required)
26037  Decompressive fasciotomy, hand (excludes 26035)
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
26359 Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon
26372 secondary with free graft (includes obtaining graft), each tendon
26373 secondary without free graft, each tendon
26390 Excision flexor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod
26392 Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod
26410 Repair, extensor tendon, primary or secondary; without free graft, each tendon
26412 with free graft (includes obtaining graft), each tendon
26415 Excision of extensor tendon, implantation of synthetic rod for delayed tendon graft, hand or finger, each rod (Report required)
26416 Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod (Report required)
26418 Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon
26420 with free graft (includes obtaining each tendon graft)
26426 Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); using local tissue(s), including lateral band(s), each finger
26428 with free graft (includes obtaining graft), each finger
26432 Closed treatment of distal extensor tendon insertion, with or without percutaneous pinning (eg, mallet finger)
26433 Repair extensor tendon, distal insertion, primary or secondary; without graft (eg, mallet finger)
26434 with free graft (includes obtaining graft)
26437  Realignment of extensor tendon, hand, each tendon
26440  Tenolysis, flexor tendon; palm OR finger, each tendon
26442    palm AND finger, each tendon
26445  Tenolysis, extensor tendon, hand or finger; each tendon
26449  Tenolysis, complex, extensor tendon, finger, including forearm, each tendon
26450  Tenotomy, flexor, palm, open, each tendon
26455  Tenotomy, flexor, finger, open, each tendon
26460  Tenotomy, extensor, hand or finger, open, each tendon
26471  Tenodesis; of proximal interphalangeal joint, each joint
26474    of distal joint, each joint
26476  Lengthening of tendon, extensor, hand or finger, each tendon
26477  Shortening of tendon, extensor, hand or finger, each tendon
26478  Lengthening of tendon, flexor, hand or finger, each tendon
26479  Shortening of tendon, flexor, hand or finger, each tendon
26480  Transfer or transplant of tendon, carpometacarpal area or dorsum of hand, without free graft, each tendon
26483    with free tendon graft (includes obtaining graft), each tendon
26485  Transfer or transplant of tendon, palmar; without free tendon graft, each tendon
26489    with free tendon graft (includes obtaining graft), each tendon
26490  Opponensplasty; superficialis tendon transfer type, each tendon
26492    tendon transfer with graft (includes obtaining graft), each tendon
26494    hypothenar muscle transfer
26496    other methods
26497  Transfer of tendon to restore intrinsic function; ring and small finger
26498    all four fingers
26499  Correction claw finger, other methods (Report required)
26500  Reconstruction of tendon pulley, each tendon; with local tissues (separate procedure)
26502    with tendon or fascial graft (includes obtaining graft) (separate procedure)
26508  Release of thenar muscle(s) (eg, thumb contracture)
26510  Cross intrinsic transfer, each tendon (Report required)
26516  Capsulodesis, metacarpophalangeal joint; single digit
26517    two digits
26518    three or four digits
26520  Capsulectomy or capsulotomy; metacarpophalangeal joint, each joint
26525    interphalangeal joint, each joint
26530  Arthroplasty, metacarpophalangeal joint; each joint
26531    with prosthetic implant, each joint
26535  Arthroplasty interphalangeal joint; each joint
26536    with prosthetic implant, each joint
26540  Repair of collateral ligament, metacarpophalangeal or interphalangeal joint
26541  Reconstruction, collateral ligament, metacarpophalangeal joint, single, with tendon or fascial graft (includes obtaining graft)
26542 with local tissue (eg, adductor advancement)
26545 Repair non-union, metacarpal or phalanx, (includes obtaining bone graft with or without external or internal fixation)
26548 Repair and reconstruction, finger, volar plate, interphalangeal joint
26550 Pollicization of a digit
26551 Transfer, toe-to-hand with microvascular anastomosis; great toe wrap around with bone graft (Report required)
26553 other than great toe, single (Report required)
26554 other than great toe, double (Report required)
26555 Transfer, finger to another position without microvascular anastomosis (Report required)
26556 Transfer, free toe joint, with microvascular anastomosis (Report required)
26560 Repair of syndactyly (web finger), each web space; with skin flaps
26561 with skin flaps and grafts
26562 complex (eg, involving bone, nails)
26565 Osteotomy; metacarpal, each
26567 phalanx of finger, each
26568 Osteoplasty, lengthening, metacarpal or phalanx (Report required)
26580 Repair cleft hand (Report required)
26587 Reconstruction of polydactylyous digit, soft tissue and bone
26590 Repair macrodactyly, each digit
26591 Repair, intrinsic muscles of hand, each muscle
26593 Release, intrinsic muscles of hand, each muscle
26596 Excision of constricting ring of finger, with multiple Z-plasties

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

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

AMPUTATION

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

OTHER PROCEDURES

26989  Unlisted procedure, hands or fingers

PELVIS AND HIP JOINT

Including head and neck of femur.

INCISION

26990  Incision and drainage; pelvis or hip joint area; deep abscess or hematoma
26991  infected bursa
26992  Incision, bone cortex, pelvis and/or hip joint (eg, for osteomyelitis or bone
   abscess)
27000  Tenotomy, adductor of hip, percutaneous, (separate procedure)
27001  Tenotomy, adductor of hip, open
27003  Tenotomy, adductor, subcutaneous, open, with obturator neurectomy
27005  Tenotomy, hip flexor(s), open (separate procedure)
27006  Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)
27025  Fasciotomy, hip or thigh, any type
(For 27001, 27003, 27025, to report bilateral procedures, use modifier -50)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27027</td>
<td>Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/ or tensor fascia lata muscle), unilateral</td>
</tr>
<tr>
<td></td>
<td>(To report bilateral procedure, use modifier -50)</td>
</tr>
<tr>
<td>27030</td>
<td>Arthrotomy, hip, with drainage (eg, infection)</td>
</tr>
<tr>
<td>27033</td>
<td>Arthrotomy, hip, including exploration or removal of loose or foreign body</td>
</tr>
<tr>
<td>27035</td>
<td>Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral or obturator nerves (Report required)</td>
</tr>
<tr>
<td>27036</td>
<td>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)</td>
</tr>
</tbody>
</table>

**EXCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27040</td>
<td>Biopsy, soft tissues of pelvis and hip area; superficial</td>
</tr>
<tr>
<td>27041</td>
<td>deep subfascial or intramuscular</td>
</tr>
<tr>
<td>27043</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater</td>
</tr>
<tr>
<td>27045</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater</td>
</tr>
<tr>
<td>27047</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm</td>
</tr>
<tr>
<td>27048</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm</td>
</tr>
<tr>
<td>27049</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm</td>
</tr>
<tr>
<td>27050</td>
<td>Arthrotomy, with biopsy; sacroiliac joint</td>
</tr>
<tr>
<td>27052</td>
<td>hip joint</td>
</tr>
<tr>
<td>27054</td>
<td>Arthrotomy with synovectomy, hip joint</td>
</tr>
<tr>
<td>27057</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>(To report bilateral procedure, use modifier -50)</td>
</tr>
<tr>
<td>27059</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater</td>
</tr>
<tr>
<td>27060</td>
<td>Excision; ischial bursa</td>
</tr>
<tr>
<td>27062</td>
<td>trochanteric bursa or calcification</td>
</tr>
<tr>
<td>27065</td>
<td>Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; superficial, includes autograft, when performed</td>
</tr>
<tr>
<td>27066</td>
<td>deep (subfascial), includes autograft, when performed</td>
</tr>
<tr>
<td>27067</td>
<td>with autograft requiring separate incision</td>
</tr>
<tr>
<td>27070</td>
<td>Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial</td>
</tr>
</tbody>
</table>
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)
   (Report required)
27110  Transfer iliopsoas; to greater trochanter of femur
27111  to femoral neck
27120  Acetabuloplasty; (eg, Whitman, Colonna Haygroves, or cup type)
27122  resection, femoral head (Girdlestone procedure)
27125  Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)
27130  Arthroplasty, acetabular and proximal femoral prosthetic replacement, (total hip arthroplasty), with or without autograft or allograft
27132  Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
27134  Revision of total hip arthroplasty; both components, with or without autograft or
allograft
27137  acetabular component only, with or without autograft or allograft
27138  femoral component only, with or without allograft
27140  Osteotomy and transfer of greater trochanter of femur (separate procedure)
27146  Osteotomy, iliac, acetabular or innominate bone;
27147  with open reduction of hip
27151  with femoral osteotomy
27156  with femoral osteotomy and with open reduction of hip
27158  Osteotomy, pelvis, bilateral (eg, congenital malformation)
27161  Osteotomy, femoral neck (separate procedure)
27165  Osteotomy, intertrochanteric or subtrochanteric including internal or external
fixation and/or cast
27170  Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area
(includes obtaining bone graft)
27175  Treatment of slipped femoral epiphysis; by traction, without reduction
27176  by single or multiple pinning, in situ
27177  Open treatment of slipped femoral epiphysis; single or multiple pinning or bone
graft (includes obtaining graft)
27178  closed manipulation with single or multiple pinning
27179  osteoplasty of femoral neck (Heyman type procedure)
27181  osteotomy and internal fixation
27185  Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur
27187  Prophylactic treatment (nailing, pinning, plating or wiring) with or without
methylmethacrylate, femoral neck and proximal femur

FRACTURE AND/OR DISLOCATION
27193  Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation;
without manipulation
27194  with manipulation, requiring more than local anesthesia
27200  Closed treatment of coccygeal fracture
27202  Open treatment of coccygeal fracture (Report required)
27215  Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s),
unilateral, (eg, pelvic fracture(s) which do not disrupt the pelvic ring), with
internal fixation
27216  Percutaneous skeletal fixation of posterior pelvic bone fracture and/or
dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes
ipsilateral ilium, sacroiliac joint and/or sacrum)
27217  Open treatment of anterior pelvic bone fracture and/or dislocation for fracture
patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when
performed (includes pubic symphysis and/or ipsilateral superior/inferior rami)
27218  Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum) 
(To report bilateral procedure, report 27215, 27216, 27217, 27218 with modifier -50)
27220  Closed treatment of acetabulum (hip socket) fracture(s); without manipulation
27222  with manipulation, with or without skeletal traction
27226  Open treatment of posterior or anterior acetabular wall fracture, with internal fixation
27227  Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation
27228  Open treatment of acetabular fracture(s) involving anterior and posterior (two) columns, includes T-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture; with internal fixation
27230  Closed treatment of femoral fracture, proximal end, neck; without manipulation
27232  with manipulation, with or without skeletal traction
27235  Percutaneous skeletal fixation of femoral fracture, proximal end, neck
27236  Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement
27238  Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; without manipulation
27240  with manipulation, with or without skin or skeletal traction
27244  Treatment of intertrochanteric, peritrochanteric or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage
27245  with intramedullary implant, with or without interlocking screws and/or cerclage
27246  Closed treatment of greater trochanteric fracture, without manipulation
27248  Open treatment of greater trochanteric fracture, includes internal fixation, when performed
27250  Closed treatment of hip dislocation, traumatic; without anesthesia
27252  requiring anesthesia
27253  Open treatment of hip dislocation, traumatic, without internal fixation
27254  Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation
27256  Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; without anesthesia, without manipulation
27257  with manipulation, requiring anesthesia
27258  Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc);
27259  with femoral shaft shortening
27265  Closed treatment of post hip arthroplasty dislocation; without anesthesia
27266  requiring regional or general anesthesia
27267  Closed treatment of femoral fracture, proximal end, head; without manipulation
27268  Closed treatment of femoral fracture, proximal end, head; with manipulation
27269  Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed

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

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

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

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

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

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

EXCISION

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

INTRODUCTION OR REMOVAL

27370  Injection of contrast for knee arthrography
Physician - Procedure Codes, Section 5 - Surgery

(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
27407 cruciate
27409 collateral and cruciate ligaments
27410 Osteochondral allograft, knee, open
27415 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 **(Report required)**
27430 Quadricepsplasty (eg, Bennett or Thompson type)
27435 Capsulotomy, posterior release, knee
27437 Arthroplasty, patella; without prosthesis **(Report required)**
27438 with prosthesis **(Report required)**
27440 Arthroplasty, knee, tibial plateau;
27441 with debridement and partial synovectomy
27442 Arthroplasty, femoral 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, epiphysial, 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 epiphysyeal separation
27510 Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation
27511 Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed
27513 Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed
27514 Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed
27516 Closed treatment of distal femoral epiphyseal separation; without manipulation (Report required)
27517 with manipulation, with or without skin or skeletal traction (Report required)
27519 Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed
27520 Closed treatment of patellar fracture, without manipulation
27524 Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair
27530 Closed treatment of tibial fracture, proximal (plateau); without manipulation
27532 with or without manipulation, with skeletal traction
27535 Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed
27536 bicondylar, with or without internal fixation
27538 Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation
27540 Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed
27550  Closed treatment of knee dislocation; without anesthesia
27552  requiring anesthesia
27556  Open treatment of knee dislocation, includes internal fixation, when performed;
       without primary ligamentous repair or augmentation/reconstruction
27557  with primary ligamentous repair
27558  with primary ligamentous repair, with augmentation/reconstruction
27560  Closed treatment of patellar dislocation; without anesthesia
27562  requiring anesthesia
27566  Open treatment of patellar dislocation, with or without partial or total
       patellectomy

**MANIPULATION**

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

**ARTHRODESIS**

27580  Arthrodesis, knee, any technique

**AMPUTATION**

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

**OTHER PROCEDURES**

27599  Unlisted procedure, femur or knee

**LEG (TIBIA AND FIBULA) AND ANKLE JOINT**

**INCISION**

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

EXCISION

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

INTRODUCTION OR REMOVAL

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

REPAIR, REVISION, AND/OR RECONSTRUCTION

27650  Repair, primary, open or percutaneous ruptured Achilles tendon;
27652 with graft (includes obtaining graft)
27654 Repair, secondary, ruptured Achilles tendon, with or without graft
27656 Repair, fascial defect of leg
27658 Repair or suture of flexor tendon, leg; primary, without graft, each tendon
27659 secondary with or without graft, each tendon
27664 Repair, extensor tendon, leg; primary, without graft, each tendon
27665 secondary with or without graft, each tendon \textbf{(Report required)}
27667 Repair dislocating peroneal tendons; without fibular osteotomy
27668 with fibular osteotomy
27670 Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon
27671 multiple tendons (through same incision(s))
27675 Lengthening or shortening of tendon; leg or ankle; single tendon (separate procedure)
27676 multiple tendons (through same incision), each
27677 Gastrocnemius recession (eg, Strayer procedure)
27680 Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)
27681 deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)
27682 each additional tendon
(\textbf{List separately in addition to primary procedure})
(\textbf{Use 27692 in conjunction with 27690, 27691})
27685 Repair, primary, disrupted ligament, ankle; collateral
27686 both collateral ligaments
27695 Repair, secondary disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)
27698 Arthroplasty, ankle;
27702 with implant (total ankle)
27703 revision, total ankle \textbf{(Report required)}
27705 Removal of ankle implant
27706 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 (Report required)
27730 Arrest, epiphyseal (epiphysiodesis), open; distal tibia
27732  distal fibula
27734  distal tibia and fibula
27740 Arrest epiphyseal, (epiphysiodesis), any method; combined, proximal and distal
tibia and fibula;
27742  and distal femur
27745 Prophylactic treatment (nailing, pinning, plating or wiring) with or without
methylmethacrylate, tibia

FRACTURE AND/OR DISLOCATION

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

**MANIPULATION**

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

**ARTHRODESIS**

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

**AMPUTATION**

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

**OTHER PROCEDURES**

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

**FOOT AND TOES**

**INCISION**

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

**EXCISION**

28039  Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater
28041  Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater
28043  Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm
28045  Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm
28046  Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm
28047  3 cm or greater
28050  Arthrotomy with biopsy; intertarsal or tarsometatarsal joint
28052  metatarsophalangeal joint
28054  interphalangeal joint
28055  Neurectomy, intrinsic musculature of foot
28060  Fasciectomy, plantar fascia; partial (separate procedure)
28062  radical (separate procedure)
28070  Synovectomy; intertarsal or tarsometatarsal joint, each
28072  metatarsophalangeal joint, each
28080  Excision of interdigital (Morton) neuroma, single, each
28086  Synovectomy, tendon sheath, foot; flexor
28088  extensor
28090  Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (cyst or ganglion); foot
28092  toe(s), each
28100  Excision or curettage of bone cyst or benign tumor, talus or calcaneus;
28102  with iliac or other autograft (includes obtaining graft)
28103  with allograft
28104  Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus;
28106  with iliac or other autograft (includes obtaining graft)
28107  with allograft
28108  Excision or curettage of bone cyst or benign tumor, phalanges of foot
28110  Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
28111  Ostectomy, complete excision; first metatarsal head
28112  other metatarsal head (second, third or fourth)
28113  fifth metatarsal head
28114  all metatarsal heads, with partial proximal phalanectomy, 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  Takedown (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)  
(Report required)  
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

28290  Correction hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (Silver type procedure)

28292  Keller, McBride or Mayo type procedure

28293  resection of joint with implant

28294  with tendon transplants (Joplin type procedure)

28296  with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)

28297  Lapidus- type procedure

28298  by phalanx osteotomy

28299  by double osteotomy

28300  Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation

28302  talus

28304  Osteotomy, tarsal bones, other than calcaneus or talus;

28305  with autograft (includes obtaining graft) (eg, Fowler type)

28306  Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal

28307  first metatarsal with autograft (other than first toe)

28308  other than first metatarsal, each

28309  multiple, (eg, Swanson type cavus foot procedure) (Report required)

28310  Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)

28312  other phalanges, any toe

28313  Reconstruction, angular deformity of toe, soft tissue procedures only (overlapping second toe, fifth toe, curly toes)

28315  Sesamoidectomy, first toe (separate procedure)

28320  Repair of nonunion or malunion; tarsal bones

28322  metatarsal, with or without bone graft (includes obtaining graft)

28340  Reconstruction, toe, macrodactyly; soft tissue resection

28341  requiring bone resection

28344  Reconstruction, toe(s); polydactyly

28345  syndactyly, with or without skin graft(s), each web

28360  Reconstruction, cleft foot

FRACTURE AND/OR DISLOCATION

28400  Closed treatment of calcaneal fracture; without manipulation

28405  with manipulation
28406 Percutaneous skeletal fixation of calcaneal fracture, with manipulation
28415 Open treatment of calcaneal fracture, includes internal fixation, when performed;
28420 with primary iliac or other autogenous bone graft (includes obtaining graft)
28430 Closed treatment of talus fracture; without manipulation
28435 with manipulation
28436 Percutaneous skeletal fixation of talus fracture, with manipulation
28445 Open treatment of talus fracture, includes internal fixation, when performed
28446 Open osteochondral autograft, talus (includes obtaining graft[s])
(Do not report 28446 in conjunction with 27705, 27707)
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
28520 Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each
28530 Closed treatment of sesamoid fracture (Report required)
28531 Open treatment of sesamoid fracture, with or without internal fixation (Report required)
28540 Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia
28545 requiring anesthesia
28546 Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation
28555  Open treatment of tarsal bone dislocation, includes internal fixation, when performed
28570  Closed treatment of talotarsal joint dislocation; without anesthesia
28575  requiring anesthesia
28576  Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation
28585  Open treatment of talotarsal joint dislocation, includes internal fixation, when performed
28600  Closed treatment of tarsometatarsal joint dislocation; without anesthesia
28605  requiring anesthesia
28606  Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation
28615  Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed
28630  Closed treatment of metatarsophalangeal joint dislocation; without anesthesia
28635  requiring anesthesia
28636  Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation
28645  Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed
28660  Closed treatment of interphalangeal joint dislocation; without anesthesia
28665  requiring anesthesia
28666  Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation
28675  Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed

**ARTHRODESIS**

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

**AMPUTATION**

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

OTHER PROCEDURES

28899  Unlisted procedure, foot or toes

APPLICATION OF CASTS AND STRAPPING

(Separate Procedure Only)

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

BODY AND UPPER EXTREMITY

CASTS

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

SPLINTS

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

LOWER EXTREMITY

CASTS

29305  Application of hip spica cast; one leg
29325  one and one-half spica or both legs
Physician - Procedure Codes, Section 5 - Surgery

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 claviclectomy including distal articular surface (Mumford procedure)
29825  with lysis and resection of adhesions with or without manipulation
29826  decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to primary procedure)
Use 29826 in conjunction with 29806-29825, 29827, 29828)
29827  with rotator cuff
29828  Arthroscopy, shoulder, surgical; biceps tenodesis
(Do not report 29828 in conjunction with 29805, 29820, 29822)
29830  Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
29834  Arthroscopy, elbow, surgical; with removal of loose body or foreign body
29835  synovectomy, partial
29836  synovectomy, complete
29837  debridement, limited
29838  debridement, extensive
29840  Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)
29843  Arthroscopy, wrist, surgical; for infection, lavage and drainage
29844  synovectomy, partial
29845  synovectomy, complete
29846  excision and/or repair of triangular fibrocartilage and/or joint debridement
29847  internal fixation for fracture or instability
29848  Endoscopy, wrist, surgical, with release of transverse carpal ligament
29850  Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)
29851  with internal or external fixation (includes arthroscopy)
29855  Arthroscopically aided treatment of tibial fracture, proximal (plateau);
unicondylar, includes internal fixation, when performed (includes arthroscopy)
29856  bicondylar, includes internal fixation, when performed (includes arthroscopy)
29860  Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)
29861  Arthroscopy, hip, surgical; with removal of loose body or foreign body
29862  with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
29863  with synovectomy
29866  Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])
       (Do not report 29866 in conjunction with 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)
29867  osteochondral allograft (eg, mosaicplasty)
       (Do not report 29867 in conjunction with 27570, 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)
       (Do not report 29867 in conjunction with 27415)
29868  meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
       (Do not report 29868 in conjunction with 29870, 29871, 29875, 29880, 29883, 29884 when performed at the same session or 29874, 29877, 29881, 29882 when performed in the same compartment)
29870  Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29871  Arthroscopy, knee, surgical; for infection, lavage and drainage
29873  with lateral release
29874  for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)
29875  synovectomy, limited (eg, plica or shelf resection) (separate procedure)
29876  synovectomy, major, two or more compartments (eg, medial or lateral)
29877  debridement/shaving of articular cartilage (chondroplasty)
29879  abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
29880  with meniscectomy (medial AND lateral, including any meniscal shaving)
       including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29881  with meniscectomy (medial OR lateral, including any meniscal shaving)
       including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29882  with meniscus repair (medial or lateral)
29883  with meniscus repair (medial and lateral)
29884  with lysis of adhesions with or without manipulation (separate procedure)
29885  drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)
29886  drilling for intact osteochondritis dissecans lesion
29887  drilling for intact osteochondritis dissecans lesion with internal fixation
29888  Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29889  Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction (Procedures 29888 and 29889 should not be used with reconstruction procedures 27427-27429)
29891  Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and/or tibia, including drilling of the defect
29892  Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)
29893  Endoscopic plantar fasciotomy
29894  Arthroscopy ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body
29895  synovectomy, partial
29897  debridement, limited
29898  debridement, extensive
29899  with ankle arthrodesis
29900  Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy (Do not report 29900 with 29901, 29902)
29901  Arthroscopy, metacarpophalangeal joint, surgical; with debridement with reduction of displaced ulnar collateral ligament (eg, Stenar Lesion)
29902  Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body
29904  Arthroscopy, subtalar joint, surgical; with synovectomy
29905  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) 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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30000</td>
<td>Drainage abscess or hematoma, nasal, internal approach</td>
</tr>
<tr>
<td>30020</td>
<td>Drainage abscess or hematoma, nasal septum</td>
</tr>
<tr>
<td>30100</td>
<td>Biopsy, intranasal</td>
</tr>
<tr>
<td>30110</td>
<td>Excision, nasal polyp(s), simple</td>
</tr>
<tr>
<td></td>
<td>(30110 would normally be completed in an office setting)</td>
</tr>
<tr>
<td></td>
<td>(To report bilateral procedure, use modifier -50)</td>
</tr>
<tr>
<td>30115</td>
<td>Excision, nasal polyp(s), extensive</td>
</tr>
<tr>
<td></td>
<td>(30115 would normally require the facilities available in a hospital setting)</td>
</tr>
<tr>
<td></td>
<td>(To report bilateral procedure, use modifier -50)</td>
</tr>
<tr>
<td>30117</td>
<td>Excision or destruction, (eg, laser), intranasal lesion; internal approach</td>
</tr>
<tr>
<td>30118</td>
<td>external approach (lateral rhinotomy)</td>
</tr>
<tr>
<td>30120</td>
<td>Excision or surgical planing of skin of nose for rhinophyma</td>
</tr>
<tr>
<td>30124</td>
<td>Excision dermoid cyst, nose; simple, skin, subcutaneous</td>
</tr>
<tr>
<td>30125</td>
<td>complex, under bone or cartilage</td>
</tr>
<tr>
<td>30130</td>
<td>Excision inferior turbinate, partial or complete, any method</td>
</tr>
<tr>
<td>30135</td>
<td>Submucous resection inferior turbinate, partial or complete, any method</td>
</tr>
<tr>
<td></td>
<td>(Do not report 30130 or 30140 in conjunction with 30801, 30802, 30930)</td>
</tr>
<tr>
<td>30150</td>
<td>Rhinectomy; partial</td>
</tr>
<tr>
<td>30160</td>
<td>total</td>
</tr>
</tbody>
</table>

**INTRODUCTION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30200</td>
<td>Injection into turbinate(s), therapeutic</td>
</tr>
<tr>
<td>30210</td>
<td>Displacement therapy (Proetz type)</td>
</tr>
<tr>
<td>30220</td>
<td>Insertion, nasal septal prosthesis (button)</td>
</tr>
</tbody>
</table>

**REMOVAL OF FOREIGN BODY**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30300</td>
<td>Removal foreign body, intranasal; office type procedure</td>
</tr>
<tr>
<td>30310</td>
<td>requiring general anesthesia</td>
</tr>
<tr>
<td>30320</td>
<td>by lateral rhinotomy</td>
</tr>
</tbody>
</table>

**REPAIR**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>
30460 Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462 tip, septum, osteotomies
30465 Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
(30465 excludes obtaining graft. For graft procedure, see 20900-20926, 21210)
(30465 is used to report a bilateral procedure)
30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30540 Repair choanal atresia; intranasal
30545 transpalatine
(Do not report modifier –63 in conjunction with 30540, 30545)
30560 Lysis intranasal synechia
30580 Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)
30600 oronasal
30620 Septal or other intranasal dermatoplasty (does not include obtaining graft)
30630 Repair nasal septal perforations

DESTRUCTION

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

OTHER PROCEDURES

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

**ACCESSORY SINUSES**

**INCISION**

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

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

**EXCISION**

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

**ENDOSCOPY**

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

31231  Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
31233 Nasal/sinus endoscopy, diagnostic; with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)

31235 Nasal/sinus endoscopy, diagnostic; 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 Nasal/sinus endoscopy, surgical; 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

**LARYNX**

**EXCISION**
31300  Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectomy
31320  diagnostic
31360  Laryngectomy; total, without radical neck dissection
31365  total, with radical neck dissection
31367  subtotal supraglottic, without radical neck dissection
31368  subtotal supraglottic, with radical neck dissection
31370  Partial laryngectomy (hemilaryngectomy); horizontal
31375  laterovertical
31380  anterovertical
31382  antero-lateral-vertical
31390  Pharyngolaryngectomy, with radical neck dissection; without reconstruction
31395  with reconstruction
31400  Arytenoidectomy or arytenoidopexy, external approach
31420  Epiglottidectomy

INTRODUCTION

31500  Intubation, endotracheal, emergency procedure

ENDOSCOPY

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

31505  Laryngoscopy, indirect; diagnostic (separate procedure)
31510  with biopsy
31511  with removal of foreign body
31512  with removal of lesion
31513  with vocal cord injection (Report required)
31515  Laryngoscopy, direct, with or without tracheoscopy; for aspiration
31520  diagnostic, newborn
   (Do not report 31520 with modifier –63)
31525  diagnostic, except newborn
31526  diagnostic, with operating microscope or telescope
31527  with insertion of obturator (Report required)
31528  with dilation, initial
31529  with dilation, subsequent (Report required)
31530  Laryngoscopy, direct, operative, with foreign body removal;
31531  with operating microscope or telescope
31535  Laryngoscopy, direct, operative, with biopsy;
31536  with operating microscope or telescope
31540  Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis;

31541  with operating microscope or telescope

31545  Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)

31546  reconstruction with graft(s) (includes obtaining autograft)  
(Do not report 31546 in addition to 20926 for graft harvest)  
(Do not report 31545 or 31546 in conjunction with 31540, 31541)

31560  Laryngoscopy, direct, operative, with arytenoidectomy;

31561  with operating microscope or telescope

31570  Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;

31571  with operating microscope or telescope

31575  Laryngoscopy, flexible fiberoptic; diagnostic

31576  with biopsy

31577  with removal of foreign body

31578  with removal of lesion

31579  Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy

REPAIR

31580  Laryngoplasty; for laryngeal web, two stage, with keel insertion and removal

31582  for laryngeal stenosis, with graft or core mold, including tracheotomy

31584  with open reduction of fracture

31587  Laryngoplasty, cricoid split

31588  Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy)

31590  Laryngeal reinnervation by neuromuscular pedicle

DESTRUCTION

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

OTHER PROCEDURES

31599  Unlisted procedure, larynx

TRACHEA AND BRONCHI

INCISION

31600  Tracheostomy, planned (separate procedure);

31601  under two years

31603  Tracheostomy, emergency procedure; transtracheal
31605  cricothyroid membrane
31610  Tracheostomy, fenestration procedure with skin flaps
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
31620  Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s)
          (List separately in addition to primary procedure(s))
          (Use 31620 in conjunction with 31622-31646)
31622  Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)
          with brushing or protected brushings
          with bronchial alveolar lavage
          with bronchial or endobronchial biopsy(s), single or multiple sites
          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)
          (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
Physician - Procedure Codes, Section 5 - Surgery

(List separately in addition to primary procedure)
(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
(31637 should be reported only once regardless of how many transbronchial needle aspiration biopsies are performed in the trachea or the additional lobe)

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)
31642 with placement of catheter(s) for intracavitary radioelement application
31643 with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess)
31645 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
31648 with removal of bronchial valve(s), initial lobe
31649 with removal of bronchial valve(s), each additional lobe
(31649 should be reported only once regardless of how many transbronchial needle aspiration biopsies are performed in the trachea or the additional lobe)

31650 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])

INTRODUCTION

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

EXCISION, REPAIR

31750 Tracheoplasty; cervical
31755 tracheopharyngeal fistulization, each stage
31760 intrathoracic
31766  Carinal reconstruction (Report required)
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
(Do not report 32096 or 32097 in conjunction with 32440, 32442, 32445, 32488)
32097  Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
32098  Thoracotomy, with biopsy(ies) of pleura
32100  Thoracotomy; with exploration
(Do not report 32100 in conjunction with 19260, 19271, 19272, 32503, 32504)
32110  with control of traumatic hemorrhage and/or repair of lung tear
32120  for postoperative complications
32124  with open intrapleural pneumonolysis
32140  with cyst(s) removal, includes pleural procedure when performed
32141  with resection-plication of bullae, includes any pleural procedure when performed
32150  with removal of intrapleural foreign body or fibrin deposit
32151  with removal of intrapulmonary foreign body
32160  with cardiac massage
32200  Pneumonostomy; with open drainage of abscess or cyst
32215  Pleural scarification for repeat pneumothorax
32220  Decortication, pulmonary (separate procedure); total
32225 partial

**EXCISION**

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

**REMOVAL**

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

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

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

ENDOSCOPY
Surgical thoracoscopy always includes diagnostic thoracoscopy.

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

32601 Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac,
mediastinal or pleural space, without biopsy
32604 pericardial sac, with biopsy
32606 mediastinal space, with biopsy
32607 Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge,
incisional), unilateral
(Do not report 32607 in conjunction with 32440, 32442, 32445, 32488, 32671)
32608  with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
   (Do not report 32608 in conjunction with 32440, 32442, 32445, 32488, 32671)
32609  with biopsy(ies) of pleura
32650  Thoracoscopy, surgical; with pleurodesis, (eg, mechanical or chemical)
32651  with partial pulmonary decortication
32652  with total pulmonary decortication, including intrapleural pneumonolysis
32653  with removal of intrapleural foreign body or fibrin deposit
32654  with control of traumatic hemorrhage
32655  with resection-plication of bullae, includes any pleural procedure when performed
32656  with parietal pleurectomy
32658  with removal of clot or foreign body from pericardial sac
32659  with creation of pericardial window or partial resection of pericardial sac for drainage
32661  with excision of pericardial cyst, tumor, or mass
32662  with excision of mediastinal cyst, tumor, or mass
32663  with lobectomy (single lobe)
32664  with thoracic sympathectomy
32665  with esophagomyotomy (Heller type)
32666  with therapeutic wedge resection (eg, mass, nodule), initial unilateral
   (To report bilateral procedure, report 32666 with modifier 50)
   (List separately in addition to primary code)
   (Report 32667 only in conjunction with 32666)
32667  with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral
   (List separately in addition to primary code)
   (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) (Report required)

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

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

OTHER PROCEDURES
32997 Total lung lavage (unilateral)
32998 Ablation therapy for reduction or eradication of 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

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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33010</td>
<td>Pericardiocentesis; initial</td>
</tr>
<tr>
<td>33011</td>
<td>subsequent</td>
</tr>
<tr>
<td>33015</td>
<td>Tube pericardiotomy</td>
</tr>
<tr>
<td>33020</td>
<td>Pericardiotomy for removal of clot or foreign body (primary procedure)</td>
</tr>
<tr>
<td>33025</td>
<td>Creation of pericardial window or partial resection for drainage</td>
</tr>
<tr>
<td>33030</td>
<td>Pericardiectomy, subtotal or complete; without cardiopulmonary bypass</td>
</tr>
<tr>
<td>33031</td>
<td>with cardiopulmonary bypass</td>
</tr>
<tr>
<td>33050</td>
<td>Resection of pericardial cyst or tumor</td>
</tr>
</tbody>
</table>

**CARDIAC TUMOR**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33120</td>
<td>Excision of intracardiac tumor, resection with cardiopulmonary bypass</td>
</tr>
<tr>
<td>33130</td>
<td>Resection of external cardiac tumor (Report required)</td>
</tr>
</tbody>
</table>

**TRANSMYOCARDIAL REVASCULARIZATION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33140</td>
<td>Transmyocardial laser revascularization, by thoracotomy (separate procedure) (List separately in addition to primary procedure) (Use 33141 in conjunction with codes 33400-33496, 33510-33536, 33542)</td>
</tr>
<tr>
<td>33141</td>
<td>performed at the time of other open cardiac procedure(s)</td>
</tr>
</tbody>
</table>

**PACEMAKER OR PACING CARDIOVERTER-DEFIBRILLATOR**

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

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

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

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

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

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

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

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

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

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

33202 Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach)

33203 Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure)

33206 Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial

33207 Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator

33208 Insertion of pacemaker pulse generator only; with existing single lead

33210 Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator

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 Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator

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)

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

33219 Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator

33220 Insertion of pacemaker pulse generator only; with existing multiple leads

33221 Relocation of skin pocket for pacemaker

33222 Relocation of skin pocket for implantable defibrillator

33223 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, 33222, 33228, 33229, 33230, 33231, 33233, 33234, 33235, 33240, 33249, 33263, 33264)

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

33227 Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system

33228 dual lead system
33229 multiple lead system
(Do not report 33227-33229 in conjunction with 33233)

33230 Insertion of implantable defibrillator pulse generator with existing dual leads with existing multiple leads
(Do not report 33230, 33231, 33240 in conjunction with 33241 for removal and replacement of the pacing cardioverter-defibrillator pulse generator. Use 33262-33264, as appropriate, when pulse generator replacement is indicated)

33233 Removal of permanent pacemaker pulse generator only

33234 Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular

33235 dual lead system
33236 Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular
33237 dual lead system
33238 Removal of permanent transvenous electrode(s) by thoracotomy

33240 Insertion of implantable defibrillator pulse generator only; with existing single lead
(Use 33240, as appropriate, in addition to the epicardial lead placement codes to report the insertion of the generator when done by the same physician during the same session)

33241 Removal of implantable defibrillator pulse generator only
33243 Removal of single or dual chamber implantable defibrillator electrode(s); by thoracotomy
33244 by transverse extraction
33249 Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber
Physician - Procedure Codes, Section 5 - Surgery

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

ELECTROPHYSIOLOGIC OPERATIVE PROCEDURES

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

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

DEFINITIONS:

Limited operative ablation and reconstruction includes:

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

Extensive operative ablation and reconstruction includes:

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

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

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

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)

AORTIC VALVE

33400  Valvuloplasty, aortic valve; open, with cardiopulmonary bypass
33401  open, with inflow occlusion
33403  using transventricular dilation, with cardiopulmonary bypass (Report required)
(Do not report modifier –63 in conjunction with 33401, 33403)
33404  Construction of apical-aortic conduit
33405  Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve
33406  with allograft valve (freehand)
33410  with stentless tissue valve (Report required)
33411  Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus
33412  with transventricular aortic annulus enlargement (Konno procedure)
33413  by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)
33414 Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract
33415 Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis
33416 Ventrilcudomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy)
33417 Aortoplasty (gusset) for supravalvular stenosis

MITRAL VALVE

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

TRICUSPID VALVE

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

PULMONARY VALVE

(Do not report modifier –63 in conjunction with 33470)
33470 Valvotomy, pulmonary valve, closed heart; transventricular
33471 via pulmonary artery
33474 Valvotomy, pulmonary valve, open heart, with cardiopulmonary bypass
33475 Replacement, pulmonary valve
33476 Right ventricular resection for infundibular stenosis, with or without commissurotomy
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 cardiopulmonary bypass

33501 Repair of coronary arteriovenous or arterio-cardiac chamber fistula; without cardiopulmonary bypass (Report required)

33502 Repair of anomalous coronary artery from pulmonary artery origin; by ligation (Report required)

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

ENDOSCOPY

Surgical vascular endoscopy always includes diagnostic endoscopy.

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

VENOUS GRAFTING ONLY FOR CORONARY ARTERY BYPASS

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

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

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

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

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

COMBINED ARTERIAL-VENOUS GRAFTING FOR CORONARY BYPASS

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

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

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

33517  Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft
       (List separately in addition to primary procedure)
       (Use 33517 in conjunction with 33533-33536)
33518  two venous grafts
       (List separately in addition to primary procedure)
       (Use 33518 in conjunction with 33533-33536)
33519  three venous grafts
       (List separately in addition to primary procedure)
       (Use 33519 in conjunction with 33533-33536)
33521  four venous grafts
       (List separately in addition to primary procedure)
       (Use 33521 in conjunction with 33533-33536)
33522  five venous grafts
       (List separately in addition to primary procedure)
       (Use 33522 in conjunction with 33533-33536)
33523  six or more venous grafts
       (List separately in addition to primary procedure)
       (Use 33523 in conjunction with 33533-33536)
33530 Reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation
(List separately in addition to primary procedure)
(Use 33530 in conjunction with 33400-33496; 33510-33536, 33863)

ARTERIAL GRAFTING FOR CORONARY ARTERY BYPASS

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

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

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

33533 Coronary artery bypass, using arterial graft(s); single arterial graft
33534 two coronary arterial grafts
33535 three coronary arterial grafts
33536 four or more coronary arterial grafts
33542 Myocardial resection (eg, ventricular aneurysmectomy)
33545 Repair of postinfarction ventricular septal defect, with or without myocardial resection
(Do not report 33548 in conjunction with 32551, 33210, 33211, 33310, 33315)

CORONARY ENDARTERECTOMY

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

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

33600  Closure of atrioventricular valve (mitral or tricuspid) by suture or patch
33602  Closure of semilunar valve (aortic or pulmonary) by suture or patch
33606  Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure)
33608  Repair of complex cardiac anomaly other than pulmonary atresia with
ventricular septal defect by construction or replacement of conduit from right or
left ventricle to pulmonary artery
33610  Repair of complex cardiac anomalies (eg, single ventricle with subaortic
obstruction) by surgical enlargement of ventricular septal defect
33611  Repair of double outlet right ventricle with intraventricular tunnel repair;
33612  with repair of right ventricular outflow tract obstruction
33615  Repair of complex cardiac anomalies (eg, tricuspid atresia) by closure of atrial
septal defect and anastomosis of atria or vena cava to pulmonary artery (simple
Fontan procedure)
33617  Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan
procedure
33619  Repair of single ventricle with aortic outflow obstruction and aortic arch
hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)
33620  Application of right and left pulmonary artery bands (eg, hybrid approach stage
1)
33621  Transthoracic insertion of catheter for stent placement with catheter removal
and closure (eg, hybrid approach stage 1)
33622  Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic
left heart) with palliation of single ventricle with aortic outflow obstruction and
aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of
right and left pulmonary bands (eg, hybrid approach stage 2, Norwood,
bidirectional Glenn, pulmonary artery debanding)
(Do not report 33622 in conjunction with 33619, 33767, 33822, 33840, 33845,
33851, 33853, 3917)

SEPTAL DEFECT

33641  Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or
without patch
33645  Direct or patch closure, sinus venosus, with or without anomalous pulmonary
venous drainage
33647  Repair of atrial septal defect and ventricular septal defect, with direct or patch
closure
33660  Repair of incomplete or partial atrioventricular canal (ostium primum atrial
septal defect), with or without atrioventricular valve repair
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33702</td>
<td>Repair sinus of Valsalva fistula, with cardiopulmonary bypass;</td>
</tr>
<tr>
<td>33710</td>
<td>with repair of ventricular septal defect</td>
</tr>
<tr>
<td>33720</td>
<td>Repair sinus of Valsalva aneurysm, with cardiopulmonary bypass</td>
</tr>
<tr>
<td>33722</td>
<td>Closure of aortico-left ventricular tunnel <em>(Report required)</em></td>
</tr>
</tbody>
</table>

**VENOUS ANOMALIES**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33724</td>
<td>Repair of isolated partial anomalous pulmonary venous return (eg, scimitar syndrome)</td>
</tr>
<tr>
<td>33726</td>
<td>Repair of pulmonary venous stenosis;</td>
</tr>
<tr>
<td></td>
<td><em>(Do not report 33724, 33726 in conjunction with 32551, 33210, 33211)</em></td>
</tr>
<tr>
<td>33730</td>
<td>Complete repair of anomalous venous return (supracardiac, intracardiac, or infracardiac types)</td>
</tr>
<tr>
<td>33732</td>
<td>Repair of cor triatriatum or supravalvular mitral ring by resection of left atrial membrane</td>
</tr>
</tbody>
</table>

**SHUNTING PROCEDURES**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33735</td>
<td>Atrial septectomy or septostomy; closed heart (Blalock-Hanlon type operation)</td>
</tr>
<tr>
<td>33736</td>
<td>open heart with cardiopulmonary bypass</td>
</tr>
<tr>
<td>33737</td>
<td>open heart, with inflow occlusion <em>(Report required)</em></td>
</tr>
<tr>
<td>33750</td>
<td>Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation)</td>
</tr>
<tr>
<td>33755</td>
<td>ascending aorta to pulmonary artery (Waterston type operation)</td>
</tr>
</tbody>
</table>
(Report required)

33762 descending aorta to pulmonary artery (Potts-Smith type operation)
33764 superior vena cava to pulmonary artery for flow to one lung (classical Glenn procedure)
33766 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 VEESELS

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 (Report required)
33813 Obliteration of aortopulmonary septal defect; without cardiopulmonary bypass
33814 with cardiopulmonary bypass
33820 Repair of patent ductus arteriosus; by ligation
33822 by division, under 18 years
33824 by division, 18 years and older
33840 Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis
33845 with graft
33851 repair using either left subclavian artery or prosthetic material as gusset for enlargement
33852 Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass
33853 with cardiopulmonary bypass

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 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 (Report required)  
33926  with cardiopulmonary bypass  
(Do not report 33925, 33926 in conjunction with 33926)  

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, birth through 5 years of age  
33956  insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older
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)

33960 reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)

33962 reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (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 removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age

33965 removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older

33966 removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age

33967 removal of central cannula(e), by sternotomy or thoracotomy, birth through 5 years of age

33968 removal of central cannula(e), by sternotomy or thoracotomy, 6 years and older

33969 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)

33970 Insertion of left heart vent by thoracic incision (eg, sternotomy/thoracotomy) for ECMO/ECLS

33971 Removal of left heart vent by thoracic incision (eg, sternotomy/thoracotomy) for ECMO/ECLS

CARDIAC ASSIST

33972 Insertion of intra-aortic balloon assist device, percutaneous

33973 Removal of intra-aortic balloon assist device, percutaneous

33974 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 (Report required)
33981  Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump (Report required)
33982  Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass (Report required)
33983  with cardiopulmonary bypass (Report required)
33990  Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only
33991  both arterial and venous access, with transseptal puncture
33992  Removal of percutaneous ventricular assist device at separate and distinct session from insertion
33993  Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion

OTHER PROCEDURES
33999  Unlisted procedure, cardiac surgery

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

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

VENOUS, DIRECT OR WITH CATHETER

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

VENOUS RECONSTRUCTION

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

ENDOVASCULAR REPAIR OF ABDOMINAL AORTIC ANEURYSM

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

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

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

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

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

34800  Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis
34802  using modular bifurcated prosthesis (one docking limb)
34803  using modular bifurcated prosthesis (two docking limbs)
34804  using unibody bifurcated prosthesis
34805  using aorto-uniiliac or aorto-unifemoral prosthesis
34806  Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data  
(List separately in addition to primary procedure) 
(Do not report 34806 in conjunction with 93982)  
(Use 34806 in conjunction with 33880, 33881, 33886, 34800-34805, 34825, 34900)
34808  Endovascular placement of iliac artery occlusion device  
(List separately in addition to primary procedure)  
(Use 34808 in conjunction with codes 34800, 34805, 34813, 34825, 34826)
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  
(Use 34825, 34826 in addition to 34800-34808, 34900 as appropriate)  
34826  each additional vessel  
(List separately in addition to primary procedure)  
(Use 34826 in conjunction with code 34825)  
34830  Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis  
34831  aorto-bi-iliac prosthesis  
34832  aorto-bifemoral prosthesis
34833  Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral *(Report required)*
(Do not report 34833 in addition to 34820)
(For bilateral procedure, use modifier -50)

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

**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 endoprostheses (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, pseudoaneurysm, 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 **(Report required)**

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

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

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

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

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

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

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

35082 for ruptured aneurysm, abdominal aorta

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

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

35102 for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

35103 for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)

35111 for aneurysm, pseudoaneurysm, and associated occlusive disease, splenic artery

35112 for ruptured aneurysm, splenic artery

35121 for aneurysm, pseudoaneurysm, and associated occlusive disease, 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 (Report required)
35184 extremities (Report required)
35188 Repair, acquired or traumatic arteriovenous fistula; head and neck
35189 thorax and abdomen (Report required)
35190 extremities

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

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

35450  Transluminal balloon angioplasty, open; renal or other visceral artery
35452  aortic
35458  brachiocephalic trunk or branches, each vessel
35460  venous

PERCUTANEOUS

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

35471  Transluminal balloon angioplasty, percutaneous; renal or visceral artery
35472  aortic
35475  brachiocephalic trunk or branches, each vessel
35476  venous

BYPASS GRAFT
VEIN

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

35500 Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure
  (List separately in addition to primary procedure)
  (Use 35500 in conjunction with 33510-33536, 35556, 35566, 35571, 35583-35587)

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

35506 carotid-subclavian or subclavian-carotid
35508 carotid-vertebral
35509 carotid-contralateral carotid
35510 carotid-brachial
35511 subclavian-subclavian
35512 subclavian-brachial
35515 subclavian-vertebral
35516 subclavian-axillary
35518 axillary-axillary
35521 axillary-femoral
35522 axillary-brachial
35523 brachial-ulnar or -radial
  (Do not report 35523 in conjunction with 35206, 35500, 35525, 36838)
35525 brachial-brachial
35526 aortosubclavian, aortoinnominate, or aortocarotid
35531 aortoceliac or aortomesenteric
35533 axillary-femoral-femoral
35535 hepatorenal
  (Do not report 35535 in conjunction with 35221, 35251, 35281, 35500, 35536, 35560, 35631, 35636)
35536 splenorenal
35537 aortoiliac
  (Do not report 35537 in conjunction with 35538)
35538 aortobi-iliac
  (Do not report 35538 in conjunction with 35537)
35539 aortofemoral
  (Do not report 35539 in conjunction with 35540)
35540  aortobifemoral
(Do not report 35540 in conjunction with 35539)
35556  femoral-popliteal
35558  femoral-femoral
35560  aortorenal
35563  ilioiliac
35565  iliofemoral
35566  femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels
35567  tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial
(Do not report 35570 in conjunction with 35256, 35286)
35571  popliteal-tibial, -peroneal artery or other distal vessels
35572  Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery)
(List separately in addition to primary procedure)
(Use 35572 in conjunction with code 33510-33516, 33517-33523, 33523, 33533-33536, 34502, 35001, 35002, 35011-35022, 35102, 35103, 35121-35152, 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-ceeliac
(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)
(Do not report 35636 in conjunction with 35638, 35646)

35637 aortoiliac
(Do not report 35637 in conjunction with 35638, 35646)

35638 aortobi-iliac
(Do not report 35638 in conjunction with 35637, 35646)

35642 carotid-vertebral
35645 subclavian-vertebral
35646 aortobifemoral
35647 aortofemoral
35650 axillary-axillary
35654 axillary-femoral-femoral
35656 femoral-popliteal
35661 femoral-femoral
35663 ilioiliac
35665 iliofemoral
35666 femoral-anterior tibial, posterior tibial, or peroneal artery
35671 popliteal-tibial, or -peroneal artery

COMPOSITE GRAFTS

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

35681 Bypass graft; composite, prosthetic and vein
(List separately in addition to primary procedure)

35682 autogenous composite, two segments of veins from two locations
(List separately in addition to primary procedure)

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

ADJUVANT TECHNIQUES

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

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

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

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

**ARTERIAL TRANSPOSITION**

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

**EXCISION, EXPLORATION, REPAIR, REVISION**

35700 Reoperation, femoral-popliteal or femoral (popliteal) - anterior tibial, posterior tibial, peroneal artery or other distal vessels, more than one month after original operation
   (List separately in addition to primary procedure)
   (Use 35700 in conjunction with 35556, 35566, 35571, 35583, 35585, 35587, 35656, 35666, 35671)
35701 Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery
35721 femoral artery
35741 popliteal artery
35761 other vessels
35800 Exploration for postoperative hemorrhage, thrombosis or infection; neck
35820 chest
35840  abdomen
35860  extremity
35870  Repair of graft-enteric fistula
35875  Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula);
        with revision of arterial or venous graft
    Codes 35879 and 35881 describe open revision of graft-threaten"e
    stenoses of lower extremity arterial bypass graft(s) (previously const""""""'"""""""""""""""""""""""""""""""
        constructed with autogenous vein conduit) using vein patch angioplasty or segmental vein
        interposition techniques.
35879  Revision, lower extremity arterial bypass, without thrombectomy, open; with
        vein patch angioplasty
35881  with segmental vein interposition
35883  Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open;
        with nonautogenous patch graft (eg, Dacron, ePTFE, bovine pericardium)
        (For bilateral procedure, use modifier -50)
        (Do not report 35883 in conjunction with 35700, 35875, 35876, 35884)
            with autogenous vein patch graft
            (For bilateral procedure, use modifier -50)
            (Do not report 35884 in conjunction with 35700, 35875, 35876, 35883)
35901  Excision of infected graft; neck
35903  extremity
35905  thorax
35907  abdomen

VASCULAR INJECTION PROCEDURES

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

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

Selective vascular catheterization should be coded to include introduction all lesser
order selective catheterization used in the approach (eg, the description for a selective
right middle cerebral artery catheterization includes the introduction and placement
"e""""""e"""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""""`
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

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

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

- **36160** Introduction of needle or intracatheter, aortic, translumbar

- **36200** Introduction of catheter, aorta

- **36215** Selective catheter placement, arterial system; each first order thoracic or 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
   (Use 36227 in conjunction with 36222, 36223, or 36224)

36227  Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation
   (List separately in addition to primary procedure)

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

36430 Transfusion, blood or blood components
36440 Push transfusion, blood, 2 years or younger
36450 Exchange transfusion, blood; newborn
36455 other than newborn
36460 Transfusion, intrauterine, fetal
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 second and subsequent veins treated in a single extremity, each through separate access sites
(List separately in addition to primary procedure)
(Use 36476 in conjunction with 36475)
36478 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated

36479 second and subsequent veins treated in a single extremity, each through separate access sites
(List separately in addition to primary procedure)
(Use 36479 in conjunction with 36478)
(Do not report 36478, 36479 in conjunction with 36000-36005, 36425, 36475, 36476, 37204, 75894, 76000, 76001, 76937, 76942, 76998, 77022, 93970, 93971)

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 entire device
4) **Complete replacement** of entire device via same venous access site (complete exchange)
5) **Removal** of entire device.

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

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

If an existing central venous access device is removed and a new one placed via a separate venous access site, appropriate codes for both procedures (removal of old, if code exists, and insertion of new device) should be reported.
When imaging is used for these procedures, either for gaining access to the venous entry site or for manipulating the catheter into final central position, use 76937, 77001.

INSERTION OF CENTRAL VENOUS ACCESS DEVICE

36555  Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age
36556   age 5 years or older
36557  Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age
36558   age 5 years or older
36560  Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; under 5 years of age
36561   age 5 years or older
36563  Insertion of tunneled centrally inserted central venous access device with subcutaneous pump
36565  Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)
36566   with subcutaneous port(s)
36568  Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; under 5 years of age
36569   age 5 years or older
36570  Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age
36571   age 5 years or older

REPAIR OF CENTRAL VENOUS ACCESS DEVICE

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

PARTIAL REPLACEMENT OF CENTRAL VENOUS ACCESS DEVICE (CATHETER ONLY)

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

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

36580  Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36581 Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36582 Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access
36583 Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access
36584 Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access
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 *Report required*

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

36625  cutdown

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

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

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

TRANSCATHETER PROCEDURES

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

Mechanical thrombectomy code(s) for catheter placement(s), diagnostic studies, and other percutaneous interventions (eg, transluminal balloon angioplasty, stent placement) provided are separately reportable.
Codes 37184-37188 specifically include intraprocedural fluoroscopic radiological supervision and interpretation services for guidance of the procedure.

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

For coronary mechanical thrombectomy, use 92973.

For mechanical thrombectomy for dialysis fistula, use 36870.

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

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

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

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

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

**ARTERIAL MECHANICAL THROMBECTOMY**

(Do not report 37184, 37185, 37816 in conjunction with 76000, 76001)
37184 Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel
(Do not report 37184 in conjunction with 99143-99150)

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

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

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

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

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

OTHER PROCEDURES

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

37202  Transcatheter therapy, infusion other than for thrombolysis, any type (eg, spasmolytic, vasoconstrictive)

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)

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

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

(Do not report 37217 in conjunction with 35201,35458,36221-36227,75962 for ipsilateral services)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The embolization codes include all associated radiological supervision and interpretation, intra-procedural guidance and road mapping and imaging necessary to document completion of the procedure.
37241 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiommas, varices, varicocelies).

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

(Do not report 37242-37244 in conjunction with 75894, 75898 in the same surgical field)

**INTRAVASCULAR ULTRASOUND SERVICES**

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

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

37250 Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel

(List separately in addition to primary procedure)

37251 each additional vessel

(List separately in addition to primary procedure)

(Use 37251 in conjunction with 37250)

**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 (Report required)
37790  Penile venous occlusive procedure
37799  Unlisted procedure, vascular surgery

HEMIC AND LYMPHATIC SYSTEMS

SPLEEN
EXCISION

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

REPAIR

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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

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); allogenic transplantation per donor
38241  autologous transplantation
38242  Allogeneic lymphocyte infusions
38243  Hematopoietic progenitor cell (HPC); HPC boost

LYMPH NODES AND LYMPHATIC CHANNELS

INCISION

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

38500 Biopsy or excision of lymph node(s); open, superficial
(Do not report 38500 with 38700-38780)
38505 by needle, superficial (eg, cervical, inguinal, axillary)
38510 open, deep cervical node(s)
38520 open, deep cervical node(s) with excision scalene fat pad
38525 open, deep axillary node(s)
38530 open, internal mammary node(s) (separate procedure)
(Do not report 38530 with 38720-38746)
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)
38746 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 (Report required)

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
39400  Mediastinoscopy, includes biopsy(ies), when performed

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

OTHER PROCEDURES
40799 Unlisted procedure, lips

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

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

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

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

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

OTHER PROCEDURES

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

PALATE AND UVULA

INCISION

42000 Drainage of abscess of palate, uvula

EXCISION, DESTRUCTION

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

REPAIR

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

42299  Unlisted procedure, palate, uvula

SALIVARY GLANDS AND DUCTS

INCISION

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

EXCISION

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

REPAIR

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

OTHER PROCEDURES

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

PHARYNX, ADENOIDS, AND TONSILS

INCISION

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

EXCISION, DESTRUCTION

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

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

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

ESOPHAGUS

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

EXCISION
43100  Excision of lesion, esophagus, with primary repair; cervical approach
43101  thoracic or abdominal approach
43107  Total or near total esophagectomy, without thoracotomy; with
pharyngogastrostomy or cervical esophagogastrostomy, with or without
pyloroplasty (transhiatal)
43108  with colon interposition or small intestine reconstruction, including intestine
mobilization, preparation and anastomosis(es)
43112  Total or near total esophagectomy, with thoracotomy; with
pharyngogastrostomy or cervical esophagogastrostomy, with or without
pyloroplasty
43113  with colon interposition or small intestine reconstruction, including intestine
mobilization, preparation, and anastomosis(es)
43116  Partial esophagectomy, cervical, with free intestinal graft, including
microvascular anastomosis, obtaining the graft and intestinal reconstruction
43117  Partial esophagectomy, distal two-thirds, with thoracotomy and separate
abdominal incision, with or without proximal gastrectomy; with thoracic
esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)
43118 with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)

43121 Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty

43122 Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty

43123 with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)

43124 Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy

43130 Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach

43135 thoracic approach

**ENDOSCOPY**

43180 Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed (Do not report 43180 in conjunction with 69990)

43191 Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)

43192 with directed submucosal injection(s), any substance

43193 with biopsy, single or multiple

43194 with removal of foreign body(s)

43195 with balloon dilation (less than 30 mm diameter)

43196 with insertion of guide wire followed by dilation over guide wire

43197 Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

43198 with biopsy, single or multiple

43200 Esophagoscopy, flexible; transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

43201 with directed submucosal injection(s), any substance

43202 with biopsy, single or multiple

43204 with injection sclerosis of esophageal varices

43205 with band ligation of esophageal varices

43206 with optical endomicroscopy

43215 with removal of foreign body(s)

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

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

43211 with endoscopic mucosal resection
43212 with placement of endoscopic stent (includes pre and post-dilation and guide wire passage, when performed)
43220 with transendoscopic balloon dilation (less than 30 mm diameter)
43213 with dilation of esophagus by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)
43214 with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)
43226 with insertion of guide wire followed by passage of dilator(s) over guide wire
43227 with control of bleeding, any method
43229 with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre and post-dilation and guide wire passage, when performed)
43231 with endoscopic ultrasound examination (Do not report 43231 in conjunction with 76975)
43232 with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)
43235 Esophagastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43236 with directed submucosal injection(s), any substance
43237 with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum and adjacent structures
43238 with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)
43239 with biopsy, single or multiple
43240 with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed and endoscopic ultrasound, when performed)
43241 with insertion of intraluminal tube or catheter
43242 with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)
43243 with injection sclerosis of esophageal gastric varices
43244 with band ligation of esophageal gastric varices
43245 with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie) (Do not report 43245 in conjunction with 43256)
43246 with directed placement of percutaneous gastrostomy tube
43247 with removal of foreign body(s)
43248 with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire
43249  with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)
43233  with dilation of esophagus with balloon (30 mm diameter or larger)
        (includes fluoroscopic guidance, when performed)
43250  with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
43251  with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43252  with optical endomicroscopy
43253  with transendoscopic ultrasound-guided transmural injection or diagnostic or therapeutic substances(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)
43254  with endoscopic mucosal resection
43255  with control of bleeding, any method
43266  with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
43257  with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease
43270  with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
43259  with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis
43260  Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43261  with biopsy, single or multiple
43262  with sphincterotomy/papillotomy
43263  with pressure measurement of sphincter of Oddi
43264  with removal of calculi/debris from biliary pancreatic duct(s)
43265  with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)
43273  Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)
43274  with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent
43275  with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)
43276  with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged
Physician - Procedure Codes, Section 5 - Surgery

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

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

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

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

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

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

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

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

43289 Unlisted laparoscopy procedure, esophagus

**REPAIR**

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

43305 with repair of tracheoesophageal fistula

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

43312 with repair of tracheoesophageal fistula

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

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

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

43325 Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43327</td>
<td>Esophagogastric fundoplasty partial or complete; laparotomy</td>
</tr>
<tr>
<td>43328</td>
<td>thoracotomy</td>
</tr>
<tr>
<td>43330</td>
<td>Esophagomyotomy (Heller type); abdominal approach</td>
</tr>
<tr>
<td>43331</td>
<td>thoracic approach</td>
</tr>
<tr>
<td>43332</td>
<td>Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis</td>
</tr>
<tr>
<td>43333</td>
<td>with implantation of mesh or other prosthesis</td>
</tr>
<tr>
<td>43334</td>
<td>Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis</td>
</tr>
<tr>
<td>43335</td>
<td>with implantation of mesh or other prosthesis</td>
</tr>
<tr>
<td>43336</td>
<td>Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis</td>
</tr>
<tr>
<td>43337</td>
<td>with implantation of mesh or other prosthesis</td>
</tr>
<tr>
<td>43338</td>
<td>Esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty)</td>
</tr>
<tr>
<td></td>
<td>(List separately in addition to primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 43338 in conjunction with 43280, 43327-43337)</td>
</tr>
<tr>
<td>43340</td>
<td>Esophagojejunostomy (without total gastrectomy); abdominal approach</td>
</tr>
<tr>
<td>43341</td>
<td>thoracic approach</td>
</tr>
<tr>
<td>43351</td>
<td>Esophagostomy, fistulization of esophagus, external; thoracic approach</td>
</tr>
<tr>
<td>43352</td>
<td>cervical approach</td>
</tr>
<tr>
<td>43360</td>
<td>Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty</td>
</tr>
<tr>
<td>43361</td>
<td>with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)</td>
</tr>
<tr>
<td>43400</td>
<td>Ligation, direct, esophageal varices</td>
</tr>
<tr>
<td>43401</td>
<td>Transection of esophagus with repair, for esophageal varices</td>
</tr>
<tr>
<td>43405</td>
<td>Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation</td>
</tr>
<tr>
<td>43410</td>
<td>Suture of esophageal wound or injury; cervical approach <strong>(Report required)</strong></td>
</tr>
<tr>
<td>43415</td>
<td>transthoracic or transabdominal approach</td>
</tr>
<tr>
<td>43420</td>
<td>Closure of esophagostomy or fistula; cervical approach</td>
</tr>
<tr>
<td>43425</td>
<td>transthoracic or transabdominal approach</td>
</tr>
</tbody>
</table>

**MANIPULATION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43450</td>
<td>Dilation of esophagus; by unguided sound or bougie, single or multiple passes</td>
</tr>
<tr>
<td>43453</td>
<td>over guide wire</td>
</tr>
<tr>
<td>43460</td>
<td>Esophagogastric tamponade, with balloon (Sengstaken type)</td>
</tr>
</tbody>
</table>
OTHER PROCEDURES

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

STOMACH

INCISION

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

EXCISION

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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

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

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

INTRODUCTION

43752 Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report) (Do not report 43752 in conjunction with critical care codes 99291-99292, neonatal critical care codes 99295-99296, pediatric critical care codes 99293-99294 or low birth weight intensive care service codes 99298-99299)
43753 Gastric intubation and aspiration(s) therapeutic, necessitating physician’s skill (eg, for gastrointestinal hemorrhage), including lavage if performed
43754 Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)
43755 collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin), includes drug administration
43756 Duodenal intubation and aspiration, diagnostic, includes image guidance; single specimen (eg, bile study for crystals or afferent loop culture)
43757 collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration
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
   with vagotomy, any type
43830 Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)
   neonatal, for feeding
   (Do not report modifier 63 in conjunction with 43831)
   with construction of gastric tube (eg, Janeway procedure)
43840 Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury
   with construction of gastric tube (eg, Janeway procedure)
43842 Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843 other than vertical-banded gastroplasty
43845 Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch) (Report required)
   (Do not report 43845 in conjunction with 43633, 43847, 44130, 49000)
43846 Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
   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 Enterointerostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)
44131  from living donor
44132  from cadaver donor
44135 Intestinal allotransplantation; from cadaver donor
44136  from living donor
44137 Removal of transplanted intestinal allograft, complete (Report required)
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
44149  with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed
44150 Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy
44151  with continent ileostomy
44152 Colectomy, total, abdominal, with proctectomy; with ileostomy
44153  with continent ileostomy
44154  with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed
44155  with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed
44156  with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed
44158 Colectomy, partial, with removal of terminal ileum with ileocolostomy
44160 Colectomy, total, abdominal, with proctectomy; with ileostomy
44161  with continent ileostomy
44162  with ileoproctostomy, includes ileostomy, and rectal mucosectomy, when performed
44163 LAPAROSCOPY
Surgical laparoscopy always includes diagnostic laparoscopy.
INCISION

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

ENTEROSTOMY-EXTERNAL FISTULIZATION OF INTESTINES

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

EXCISION

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

REPAIR

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

OTHER PROCEDURES
44238 Unlisted laparoscopy procedure, intestine (except rectum)

**ENTEROSTOMY - EXTERNAL FISTULIZATION OF INTESTINES**

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

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

44312 Revision of ileostomy; simple (release of superficial scar) (separate procedure)  
44314 complicated (reconstruction in depth) (separate procedure)  
44316 Continent ileostomy (Kock procedure) (separate procedure)  
44320 Colostomy or skin level cecostomy;  
(Do not report 44320 in conjunction with 44141, 44144, 44146, 44605, 45110, 45119, 45126, 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)
Physician - Procedure Codes, Section 5 - Surgery

44377 with biopsy, single or multiple
44378 with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44379 with transendoscopic stent placement (includes predilation)
44380 Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44381 with biopsy, single or multiple
44381 with transendoscopic balloon dilation
(Do not report 44381 in conjunction with 44380,44384)
44382 with biopsy, single or multiple
44383 Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
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
44387 Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44388 with biopsy, single or multiple
44389 with removal of foreign body(s)
44390 with control of bleeding, any method (Report required)
44391 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
44392 with ablation of tumor(s), polyp(s), or other lesions(s), (includes pre- and post-dilation and guide wire passage, when performed)
44393 with removal of tumor(s), polyp(s), or other lesion(s) by snare techniques
44394 with endoscopic stent placement (including pre- and post-dilaton and guide wire passage, when performed)
44395 with endoscopic mucosal resection
44396 with directed submucosal injection(s), any substance
44397 with transendoscopic balloon dilation
44398 with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44399 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
44400 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

**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

44900  Incision and drainage of appendiceal abscess; open

EXCISION

44950  Appendectomy; (Incidental appendectomy during intra-abdominal surgery does not warrant a separate identification)

44955 when done for indicated purpose at time of other major procedure (not as separate procedure)
        (List separately in addition to primary procedure)

44960 for ruptured appendix with abscess or generalized peritonitis

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

44970  Laparoscopy, surgical, appendectomy

44980  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 supravelvator, 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 transcocygeal approach
45171  Excision of rectal tumor, transanal approach; not including muscularis propria
(ie, partial thickness)
45172  including muscularis propria (ie, full thickness)
(For destruction of rectal tumor, transanal approach, use 45190)

DESTRUCTION

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

ENDOSCOPY

DEFINITIONS:

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

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

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

(Surgical endoscopy always includes diagnostic endoscopy)

45300  Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s)
by brushing or washing (separate procedure)
45303  with dilation, (eg, balloon, guide wire, bougie)

45305  with biopsy, single or multiple

45307  with removal of foreign body

45308  with removal of single tumor, polyp, or other lesion by hot biopsy forceps
        or bipolar cautery

45309  with removal of single tumor, polyp, or other lesion by snare technique

45315  with removal of multiple tumors, polyps, or other lesions by hot biopsy
        forceps, bipolar cautery or snare technique

45317  with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery,
        laser, heater probe, stapler, plasma coagulator)

45320  with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to
        removal by hot biopsy forceps, bipolar cautery or snare technique (eg,
        laser)

45321  with decompression of volvulus

45327  with transendoscopic stent placement (includes predilation)

45330  Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by
        brushing or washing, when performed (separate procedure)

45331  with biopsy, single or multiple

45332  with removal of foreign body(s)

45333  with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps

45334  with control of bleeding, any method

45335  with directed submucosal injection(s), any substance

45337  with decompression (for pathologic distention) (eg, volvulus,
        megacolon), including placement of decompression tube when
        performed

45338  with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

45346  with ablation of tumor(s), polyp(s), or other lesions(s), (includes
        pre- and post-dilation and guide wire passage, when performed)

45340  with transendoscopic balloon dilation

45341  with endoscopic ultrasound examination

45342  with transendoscopic ultrasound guided intramural or transmural fine
        needle aspiration/biopsy(s)

45347  with placement of endoscopic stent (includes pre- and post-dilation
        and guide wire passage, when performed)

45349  with endoscopic mucosal resection

45350  with band ligation(s) (eg, hemorrhoids)

45378  Colonoscopy, flexible; diagnostic, including collection of specimen(s) by
        brushing or washing, when performed (separate procedure)

45379  with removal of foreign body(s)

45380  with biopsy, single or multiple

45381  with directed submucosal injection(s), any substance

45382  with control of bleeding, any method

45388  with ablation of tumor(s), polyp(s), or other lesions(s), (includes
pre- and post-dilation and guide wire passage, when performed)

45384 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45385 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386 with transendoscopic balloon dilation

45389 with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)

45391 with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse or ascending colon and cecum, and adjacent structures

45392 with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures

45390 with endoscopic mucosal resection

45393 with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed

45398 with band ligation(s) (eg, hemorrhoids)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

EXCISION

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

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 (Report required)
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, simple column/group;
    with fissurectomy
46258 with fistulectomy, including fissurectomy, when performed
46260 Hemorrhoidectomy, internal and external, 2 or more columns/groups;
    with fissurectomy
46261 with fistulectomy, including fissurectomy, when performed
46270 Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous
    intersphincteric
46280 transsphincteric, suprasphincteric or extrasphincteric or multiple, including
    placement of seton, when performed
        (Do not report 46280 in conjunction with 46020)
    second stage
46285 Closure of anal fistula with rectal advancement flap
46288 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)
    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
    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 (Report required)
46744  Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty; sacroperineal approach
46746  Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach (Report required)
46748  with vaginal lengthening by intestinal graft and pedicle flaps
46750  Sphincteroplasty, anal, for incontinence or prolapse; adult
46751  child
46753  Graft (Thiersch operation) for rectal incontinence and/or prolapse
46754  Removal of Thiersch wire or suture, anal canal (Report required)
46760  Sphincteroplasty, anal, for incontinence, adult; muscle transplant
46761  levator muscle imbrication (Park posterior anal repair)
46762  implantation artificial sphincter

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

**SUTURE**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>46945</td>
<td>Ligation of internal hemorrhoids; single procedure</td>
</tr>
<tr>
<td>46946</td>
<td>multiple procedures</td>
</tr>
<tr>
<td>46947</td>
<td>Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling</td>
</tr>
</tbody>
</table>

**OTHER PROCEDURES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>46999</td>
<td>Unlisted procedure, anus</td>
</tr>
</tbody>
</table>

**LIVER**

**INCISION**

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

**EXCISION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>47100</td>
<td>Biopsy of liver, wedge</td>
</tr>
<tr>
<td>47120</td>
<td>Hepatectomy, resection of liver; partial lobectomy</td>
</tr>
<tr>
<td>47122</td>
<td>trisegmentectomy</td>
</tr>
<tr>
<td>47125</td>
<td>total left lobectomy</td>
</tr>
<tr>
<td>47130</td>
<td>total right lobectomy</td>
</tr>
</tbody>
</table>
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
(Do not report 47490 in conjunction with 47505, 74305, 75989, 76942, 77002, 77012, 77021)

47500 Injection procedure for percutaneous transhepatic cholangiography

47505 Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube)

47510 Introduction of percutaneous transhepatic catheter for biliary drainage

47511 Introduction of percutaneous transhepatic stent for internal and external biliary drainage

47525 Change of percutaneous biliary drainage catheter

47530 Revision and/or reinsertion of transhepatic tube

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.

47560 Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy

47561 with guided transhepatic cholangiography with biopsy
47562 cholecystectomy
47563 cholecystectomy with cholangiography
47564 cholecystectomy with exploration of common duct
47570 cholecystoenterostomy
47579 Unlisted laparoscopy procedure, biliary tract

EXCISION
47600  Cholecystectomy;
47605  with cholangiography
47610  Cholecystectomy with exploration of common duct;
47612  with choledochoenterostomy
47620  with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography
47630  Biliary duct stone extraction, percutaneous via T-tube tract, basket or snare (eg, Burhenne technique)
47700  Exploration for congenital atresia of bile ducts, without repair, with or without liver biopsy, with or without cholangiography
47701  Portaenterostomy (eg, Kasai procedure) (Do not report modifier 63 in conjunction with 47700, 47701)
47711  Excision of bile duct tumor, with or without primary repair of bile duct; extrahepatic
47712  intraphepatic
47715  Excision of choledochal cyst

REPAIR

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

OTHER PROCEDURES

47999  Unlisted procedure, biliary tract

PANCREAS

INCISION

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

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

INTRODUCTION

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

REPAIR

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

PANCREAS TRANSPLANTATION

48554 Transplantation of pancreatic allograft
48556 Removal of transplanted pancreatic allograft
OTHER PROCEDURES

48999 Unlisted procedure, pancreas

ABDOMEN, PERITONEUM, AND OMENTUM

INCISION

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

EXCISION, DESTRUCTION

49180 Biopsy, abdominal or retroperitoneal mass, percutaneous needle
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) (Report required)
49250 Umbillectomy, omphalectomy, excision of umbilicus (separate procedure)
49255 Omentectomy, epiploectomy, resection of omentum (separate procedure)

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.
49320 Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
49321 Laparoscopy, surgical; with biopsy (single or multiple)
49322 with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)
49323 with drainage of lymphocele to peritoneal cavity
49324 with insertion of tunneled intraperitoneal catheter
49325 with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed
49326 with omentopexy (omentum tacking procedure) (List separately in addition to primary procedure) (Use 49326 in conjunction with 49324, 49325)
49327 with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to primary procedure) (Use 49327 in conjunction with laparoscopic abdominal, pelvic, or retroperitoneal procedure[s] performed concurrently)
49329 Unlisted laparoscopy procedure, abdomen, peritoneum and omentum

INTRODUCTION, REVISION AND/OR REMOVAL

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

**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.

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

**CONVERSION**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>49446</td>
<td>Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous,</td>
</tr>
<tr>
<td></td>
<td>under fluoroscopic guidance including contrast injection(s), image</td>
</tr>
<tr>
<td></td>
<td>documentation and report</td>
</tr>
<tr>
<td></td>
<td>(For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy</td>
</tr>
<tr>
<td></td>
<td>tube placement, use 49446 in conjunction with 49440)</td>
</tr>
</tbody>
</table>

**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 femoral hernia, age 5 years or over; reducible

49507 incarcerated or strangulated

49520 Repair recurrent inguinal hernia, any age; reducible

49521 incarcerated or strangulated

49525 Repair inguinal hernia, sliding, any age

49540 Repair lumbar hernia

49550 Repair initial femoral hernia, any age; reducible

49553 incarcerated or strangulated

49555 Repair recurrent femoral hernia; reducible

49557 incarcerated or strangulated

49560 Repair initial incisional or ventral hernia; reducible

49561 incarcerated or strangulated

49565 Repair recurrent incisional or ventral hernia; reducible

49566 incarcerated or strangulated

49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair) (Use 49568 in conjunction with 11004-11006, 49560-49566)

49570 Repair epigastric hernia (e.g. preperitoneal fat); reducible (separate procedure);

49572 incarcerated or strangulated

49580 Repair umbilical hernia, younger than age 5 years; reducible

49582 incarcerated or strangulated

49585 Repair umbilical hernia, age 5 years or over; reducible

49587 incarcerated or strangulated

49590 Repair spigelian hernia

49600 Repair of small omphalocele, with primary closure

49605 Repair of large omphalocele or gastroschisis; with or without prosthesis

49606 with removal of prosthesis, final reduction and closure, in operating room

49610 Repair of omphalocele (Gross type operation); first stage

49611 second stage
LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

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

SUTURE

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

OTHER PROCEDURES

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

URINARY SYSTEM

KIDNEY

INCISION

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

EXCISION

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

RENAI TRANSPANTATION

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

INTRODUCTION

RENAI PELVIS CATHERETER 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)

50392 Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous

50393 Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous

50394 Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter

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

50398 Change of nephrostomy or pyelostomy tube

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, calyceoplasty)
50500  Nephrrorrhaphy, 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
(Report required)

URETER

INCISION

50600  Ureterotomy with exploration or drainage (separate procedure)
50605  Ureterotomy for insertion of indwelling stent, all types
50610  Ureterolithotomy; upper one-third of ureter
50620  middle one-third of ureter
50630  lower one-third of ureter

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

REPAIR
50700  Ureteroplasty, plastic operation on ureter (eg, stricture)
50715  Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis
50722  Ureterolysis for ovarian vein syndrome
50725  Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava
50727  Revision of urinary-cutaneous anastomosis (any type urostomy);
      with repair of fascial defect and hernia
50740  Ureteropyelostomy, anastomosis of ureter and renal pelvis
50750  Ureterocalyceostomy, anastomosis of ureter to renal calyx
50760  Ureteroureterostomy
50770  Transureteroureterostomy, anastomosis of ureter to contralateral ureter
50780  Ureteroneocystostomy; anastomosis of single ureter to bladder
      anastomosis of duplicated ureter to bladder
50782  with extensive ureteral tailoring
50785  with vesico-psoas hitch or bladder flap
      (Codes 50780-50785 include minor procedures to prevent vesicoureteral reflux)
50800  Ureteroenterostomy, direct anastomosis of ureter to intestine
50810  Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis
50815  Ureterocolon conduit, including intestine anastomosis
50820  Ureteroileal conduit (ileal bladder), including intestine anastomosis (Bricker operation)
50825  Continent diversion, including intestine anastomosis using any segment of small and/or large bowel (Kock pouch or Camey enterocystoplasty)
50830  Urinary undiversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroenterostomy with ureteroureterostomy or ureteroneocystostomy)
50840  Replacement of all or part of ureter by intestine segment, including intestine anastomosis
50845  Cutaneous appendico-vesicostomy
50860  Ureterostomy, transplantation of ureter to skin
50900  Ureterorrhaphy, suture of ureter (separate procedure)
50920  Closure of ureterocutaneous fistula
50930  Closure of ureterovisceral fistula (including visceral repair)
50940  Delegation of ureter

**LAPAROSCOPY**

Surgical laparoscopy always includes diagnostic laparoscopy.

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

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

BLADDER

INCISION

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

REMOVAL

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

EXCISION

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

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

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

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

51725 Simple cystometrogram (CMG) (eg, spinal manometer)
51726 Complex cystometrogram (ie, calibrated electronic equipment);
51727 with urethral pressure profile studies (ie, urethral closure pressure profile), any technique
51728 with voiding pressure studies (ie, bladder voiding pressure), any technique
51729 with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique
51736 Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)
51741 Complex uroflowmetry (eg, calibrated electronic equipment)
51784 Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique
51785 Needle electromyography studies (EMG) of anal or urethral sphincter, any technique
51792 Stimulus evoked response (eg, measurement of bulbocavernous reflex latency time)
51797 Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to primary procedure) (Use 51797 in conjunction with 51728, 51729)
51798 Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging

**REPAIR**

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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy.

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

ENDOSCOPY - CYSTOSCOPY, URETHROSCOPY, CYSTOURETHROSCOPY

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

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

TRANSURETHRAL SURGERY

URETHRA AND BLADDER

52204  Cystourethroscopy, with biopsy(s)
52214  Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of
       trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
52224  Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or
       treatment of MINOR (less than 0.5 cm) lesion(s), with or without biopsy
52234  Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)
52235  MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52240  LARGE bladder tumor(s)
52250  Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration
52260  Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
52265  local anesthesia
52270  Cystourethroscopy, with internal urethrotomy; female
52275  male
52276  Cystourethroscopy, with direct vision internal urethrotomy
52277  Cystourethroscopy, with resection of external sphincter (sphincterotomy)
52281  Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
52282  Cystourethroscopy, with insertion of permanent urethral stent
52283  Cystourethroscopy, with steroid injection into stricture
52285  Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone
52287  Cystourethroscopy, with injection(s) for chemodenervation of the bladder
52290  Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral
52300  with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral
52301  with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral
52305  with incision or resection of orifice of bladder diverticulum, single or multiple
52310  Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple
52315  complicated
52317  Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)
52318  complicated or large (over 2.5 cm)

URETER AND PELVIS

Therapeutic cystourethroscopy always includes diagnostic cystourethroscopy. To report a diagnostic cystourethroscopy, use 52000. Therapeutic cystourethroscopy with ureteroscopy and/or pyeloscopy always includes diagnostic cystourethroscopy with ureteroscopy and/or pyeloscopy. To report a diagnostic cystourethroscopy with ureteroscopy and/or pyeloscopy, use 52351.
Do not report 52000 in conjunction with 52320-52343.

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

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

52320  Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)

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)

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)

52344  Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)

52351  Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic (Do not report 52351 in conjunction with 52341-52346, 52352-52355)

52352  with removal or manipulation of calculus (ureteral catheterization is included)

52353  with lithotripsy (ureteral catheterization is included)

52354  with biopsy and/or fulguration of ureteral or renal pelvic lesion

52355  with resection of ureteral or renal pelvic tumor

52356  with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

**VESICAL NECK AND PROSTATE**

52400  Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds

52402  Cystourethroscopy with transurethral resection or incision of ejaculatory ducts
52441  Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant
55242 each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)
52450  Transurethral incision of prostate
52500  Transurethral resection of bladder neck (separate procedure)
52601  Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52630  Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52640  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)
52647  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)
52648 (Do not report 52649 in conjunction with 52000, 52276, 52281, 52601, 52647, 52648, 53020, 55250)
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)
52700  Transurethral drainage of prostatic abscess

URETHRA

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 membraneous urethra
53420  Urethroplasty, two-stage reconstruction or repair of prostatic or membraneous urethra; first stage
53425   second stage
53430  Urethroplasty, reconstruction of female urethra
53431  Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg, Tenago, Leadbetter procedure)
53440  Sling operation for correction of male urinary incontinence, (eg, fascia or synthetic)
53442  Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic) *(Report required)*
53444  Insertion of tandem cuff (dual cuff)
53445  Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
53446  Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53447  Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir and cuff at the same operative session
53448  Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue (Do not report 11043 in addition to 53448)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53449</td>
<td>Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff <em>(Report required)</em></td>
</tr>
<tr>
<td>53450</td>
<td>Urethromeatoplasty, with mucosal advancement</td>
</tr>
<tr>
<td>53460</td>
<td>Urethromeatoplasty, with partial excision of distal urethral segment <em>(Richardson type procedure)</em></td>
</tr>
<tr>
<td>53500</td>
<td>Urethrolysis, transvaginal, secondary, open, including cystourethroscopy <em>(eg, postsurgical obstruction, scarring)</em></td>
</tr>
<tr>
<td></td>
<td><em>(Do not report 53500 in conjunction with 52000)</em></td>
</tr>
<tr>
<td>53502</td>
<td>Urethrorrhaphy, suture of urethral wound or injury; female <em>(Report required)</em></td>
</tr>
<tr>
<td>53505</td>
<td>penile</td>
</tr>
<tr>
<td>53510</td>
<td>perineal</td>
</tr>
<tr>
<td>53515</td>
<td>prostatomembranous</td>
</tr>
<tr>
<td>53520</td>
<td>Closure of urethrostomy or urethrocuteaneous fistula, male <em>(separate procedure)</em></td>
</tr>
<tr>
<td></td>
<td><strong>MANIPULATION</strong></td>
</tr>
<tr>
<td>53600</td>
<td>Dilation of urethral stricture by passage of sound or urethral dilator, male; initial</td>
</tr>
<tr>
<td>53601</td>
<td>subsequent</td>
</tr>
<tr>
<td>53605</td>
<td>Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction <em>(spinal) anesthesia</em></td>
</tr>
<tr>
<td>53620</td>
<td>Dilation of urethral stricture by passage of filiform and follower, male; initial</td>
</tr>
<tr>
<td>53621</td>
<td>subsequent</td>
</tr>
<tr>
<td>53660</td>
<td>Dilation of female urethra including suppository and/or instillation; initial</td>
</tr>
<tr>
<td>53661</td>
<td>subsequent</td>
</tr>
<tr>
<td>53665</td>
<td>Dilation of female urethra, general or conduction <em>(spinal) anesthesia</em></td>
</tr>
<tr>
<td></td>
<td><strong>OTHER PROCEDURES</strong></td>
</tr>
<tr>
<td>53850</td>
<td>Transurethral destruction of prostate tissue; by microwave thermotherapy</td>
</tr>
<tr>
<td>53852</td>
<td>by radiofrequency thermotherapy</td>
</tr>
<tr>
<td>53855</td>
<td>Insertion of a temporary prostatic urethral stent, including urethral measurement</td>
</tr>
<tr>
<td>53860</td>
<td>Transurethral radiofrequency micro-modeling of the female bladder neck and proximal urethra for stress urinary incontinence</td>
</tr>
<tr>
<td>53899</td>
<td>Unlisted procedure, urinary system</td>
</tr>
<tr>
<td></td>
<td><strong>MALE GENITAL SYSTEM</strong></td>
</tr>
<tr>
<td></td>
<td><strong>PENIS</strong></td>
</tr>
<tr>
<td>54000</td>
<td>Slitting of prepuce, dorsal or lateral <em>(separate procedure)</em>; newborn <em>(Do not report modifier –63 in conjunction with 54000)</em></td>
</tr>
<tr>
<td>54001</td>
<td>except newborn</td>
</tr>
</tbody>
</table>
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) *(Report required)*

**EXCISION**

54100 Biopsy of penis; (separate procedure)
54105 deep structures
54110 Excision of penile plaque (Peyronie disease);
54111 with graft to 5 cm in length
54112 with graft greater than 5 cm in length
54115 Removal foreign body from deep penile tissue (eg, plastic implant)
54120 Amputation of penis; partial
54125 complete
54130 Amputation of penis, radical; with bilateral inguinofemoral lymphadenectomy in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
54150 Circumcision, using clamp or other device with regional dorsal penile or ring block (Do not report modifier 63 in conjunction with 54150)
54160 Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less) (Do not report modifier 63 in conjunction with 54160)
54161 older than 28 days of age
54162 Lysis or excision of penile post-circumcision adhesions
54163 Repair incomplete circumcision
54164 Frenulotomy of penis (Do not report 54164 with circumcision codes 54150-54161, 54162, 54163)

**INTRODUCTION**

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

**REPAIR**

54300 Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra

54304 Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps

54308 Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm

54312 greater than 3 cm

54316 Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia

54318 Urethroplasty for third stage hypospadias repair to release penis from scrotum (eg, 3rd stage Cecil repair)

54322 One stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V-flap)

54324 with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap)

54326 with urethroplasty by local skin flaps and mobilization of urethra

54328 with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap

54332 One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap

54336 One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap

54340 Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple

54344 requiring mobilization of skin flaps and urethroplasty with flap or patch graft

54348 requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)

54352 Repair of hypospadias cripple requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as flaps or grafts

54360 Plastic operation on penis to correct angulation

54380 Plastic operation on penis for epispadias distal to external sphincter;
54385 with incontinence (Report required)
54390 with extrophy of bladder

54400 Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401 inflatable (self-contained)
<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54405</td>
<td>Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir</td>
</tr>
<tr>
<td>54406</td>
<td>Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis</td>
</tr>
<tr>
<td>54408</td>
<td>Repair of component(s) of a multi-component, inflatable penile prosthesis</td>
</tr>
<tr>
<td>54410</td>
<td>Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session</td>
</tr>
<tr>
<td>54411</td>
<td>Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue (Do not report 11043 in addition to 54411)</td>
</tr>
<tr>
<td>54415</td>
<td>Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis</td>
</tr>
<tr>
<td>54416</td>
<td>Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session</td>
</tr>
<tr>
<td>54417</td>
<td>Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue (Do not report 11043 in addition to 54417)</td>
</tr>
<tr>
<td>54420</td>
<td>Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral</td>
</tr>
<tr>
<td>54430</td>
<td>Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilateral</td>
</tr>
<tr>
<td>54435</td>
<td>Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism</td>
</tr>
<tr>
<td>54440</td>
<td>Plastic operation of penis for injury</td>
</tr>
</tbody>
</table>

**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 (Report required)

REPRODUCTIVE SYSTEM PROCEDURES

55920 Placement of needles or catheters into pelvic organs and/ or genitalia (except prostate) for subsequent interstitial radioelement application
INTERSEX SURGERY

55970  Intersex surgery; male to female (Report required)
55980  female to male (Report required)

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 (ICD-9 302.85, ICD-10 F64.1). The physician must include with the paper claim the sterilization consent form (if the procedure results in sterilization), the operation report, and copies of the two letters from New York State licensed mental health practitioners recommending the patient for surgery (see March 2015 Medicaid Update). These procedures pay by the submitted charges on the invoice.

When reporting procedure code 55970 for New York State Medicaid recipients, the following staged procedures to remove portions of the male genitalia and form female external genitals are included:

- 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 used 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 this procedure.

When reporting procedure code 55980 for New York State Medicaid recipients, the surgeon will have to identify if a phalloplasty or metoidioplasty was performed. The following staged procedures are included when reporting 55980 for a phalloplasty:

- 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 vagina is closed or removed.
- Hair removal, if clinically indicated, is included in this procedure.

For male-to-female gender reassignment surgery, 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. Physicians should bill this procedure using either code 19324 (augmentation without implant) or 19325 (augmentation with implant). For this surgery, physicians must submit a paper claim, including: the operation report, two letters recommending patient for surgery, and an explanation that patient meets criteria for surgery.
FEMALE GENITAL SYSTEM

VULVA, PERINEUM AND INTROITUS

The following definitions apply to the vulvectomy codes (56620-56640):

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

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

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

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

INCISION

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

DESTRUCTION

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

EXCISION

56605 Biopsy of vulva or perineum. (separate procedure); one lesion
56606 each separate additional lesion
   (List separately in addition to primary procedure)
   (Use 56606 in conjunction with 56605)
56620 Vulvectomy simple; partial
56625 complete
56630 Vulvectomy, radical, partial;
56631 with unilateral inguinofemoral lymphadenectomy
56632 with bilateral inguinofemoral lymphadenectomy
56633 Vulvectomy, radical, complete;
56634 with unilateral inguinofemoral lymphadenectomy
56637 with bilateral inguinofemoral lymphadenectomy
56640 Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy
   (For bilateral procedure, use modifier 50)
56700 Partial hymenectomy or revision of hymenal ring
56740 Excision of Bartholin's gland or cyst

REPAIR
56800  Plastic repair of introitus  
56805  Clitoroplasty for intersex state 
56810  Perineoplasty, repair of perineum, nonobstetrical (separate procedure)  
        (See also 56800) 

ENDOSCOPY

56820  Colposcopy of the vulva;  
56821     with biopsy(s) 

VAGINA

INCISION

57000  Colpotomy; with exploration  
57010     with drainage of pelvic abscess 
57020  Colpocentesis (separate procedure) 
57022  Incision and drainage of vaginal hematoma; obstetrical/post-partum  
57023     non-obstetrical (eg, post-trauma, spontaneous bleeding) 

DESTRUCTION

57061  Destruction of vaginal lesion(s); simple, (eg, laser surgery, electrosurgery, 
       cryosurgery, chemosurgery) 
57065     extensive, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) 

EXCISION

57100  Biopsy of vaginal mucosa; simple (separate procedure) 
57105     extensive, requiring suture (including cysts) 
57106  Vaginectomy, partial removal of vaginal wall; 
57107     with removal of paravaginal tissue (radical vaginectomy) 
57109     with removal of paravaginal tissue (radical vaginectomy) with bilateral total 
       pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy) 
57110  Vaginectomy, complete removal of vaginal wall; 
57111     with removal of paravaginal tissue (radical vaginectomy) 
57112     with removal of paravaginal tissue (radical vaginectomy) with bilateral total 
       pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy) 
57120  Colpocleisis (Le Fort Type) 
57130  Excision of vaginal septum 
57135  Excision of vaginal cyst or tumor 

INTRODUCTION

57150  Irrigation of vagina and/or application of medicament for treatment of bacterial, 
       parasitic, or fungoid disease
57155 Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy
57156 Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy
57160 Fitting and insertion of pessary or other intravaginal support device
57180 Introduction of any hemostatic agent or pack for spontaneous or traumatic nonobstetrical hemorrhage (separate procedure)

REPAIR

57200 Colporrhaphy, suture of injury of vagina (nonobstetrical)
57210 Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical)
57220 Plastic operation on urethral sphincter, vaginal approach (eg, Kelly urethral plication)
57230 Plastic repair of urethrocele
57240 Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele
57250 Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy
57260 Combined anteroposterior colporrhaphy;
57265 with enterocele repair
57267 Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach
(List separately in addition to primary procedure) (Use 57267 in addition to 45560, 57240-57265)
57268 Repair of enterocele, vaginal approach (separate procedure)
57270 Repair of enterocele, abdominal approach (separate procedure)
57280 Colpopexy, abdominal approach
57282 Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)
57283 intra-peritoneal approach (uterosacral, levator myorrhaphy)
57284 Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach (Do not report 57284 in conjunction with 51840, 51841, 51990, 57240, 57260, 57265, 58152, 58267)
57285 vaginal approach
(Do not report 57285 in conjunction with 51990, 57240, 57260, 57265, 58267)
57287 Removal or revision of sling for stress incontinence (eg, fascia or synthetic)
57288 Sling operation for stress incontinence (eg, fascia or synthetic)
57289 Pereyra procedure, including anterior colporrhaphy
57291 Construction of artificial vagina; without graft
57292 with graft
57295 Revision (including removal) of prosthetic vaginal graft, vaginal approach
57296 open abdominal approach
57300 Closure of rectovaginal fistula; vaginal or transanal approach
57305 abdominal approach
57307 abdominal approach, with concomitant colostomy
57308  transperineal approach, with perineal body reconstruction, with or without levator plication
57310  Closure of urethrovaginal fistula;
57311  with bulbocavernousus transplant (Report required)
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) (Report required)
57415  Removal of impacted vaginal foreign body (separate procedure) under anesthesia (other than local)
(For removal without anesthesia of an impacted vaginal foreign body, use the appropriate Evaluation and Management code)

**ENDOSCOPY**

57420  Colposcopy of the entire vagina, with cervix if present;
57421  with biopsy(s) of vagina/cervix
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
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
HYSTERECTOMY PROCEDURES

(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
58267 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz Type, Pereyra type, with or without endoscopic control)
58270 with repair of enterocele
58275 Vaginal hysterectomy, with total or partial vaginectomy;
58280 with repair of enterocele
58285 Vaginal hysterectomy, radical (Schauta type operation)
58290 Vaginal hysterectomy, for uterus greater than 250 grams;
58291 with removal of tube(s) and/or ovary(s)
58292 with removal of tube(s) and/or ovary(s), with repair of enterocele
58293 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58294 with repair of enterocele

INTRODUCTION

58300 Insertion of intrauterine device (IUD)
58301 Removal of intrauterine device (IUD)
58340 Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (sis) or hysterosalpingography
58346 Insertion of Heyman capsules for clinical brachytherapy
58353 Endometrial ablation, thermal, without hysteroscopic guidance
58356 Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed

REPAIR

58400 Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)
58410 with presacral sympathectomy
58520 Hysterorrhaphy, repair of ruptured uterus (nonobstetrical)
58540 Hysteroplasty, repair of uterine anomaly (Strassman type) (Report required)

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)

(Do not report 58541-58544, 58550-58552, 58553-58554, 58570-58575 in conjunction with 49320, 57000, 57180, 57410, 58140-58146, 58150, 58545, 58546, 58561, 58661, 58670, 58671)

58541 Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542 with removal of tube(s) and/or ovary(s)
58543 Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544 with removal of tube(s) and/or ovary(s)
58545 Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas
58546 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams
58548 Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed
(Do not report 58548 in conjunction with 38570-38572, 58210, 58285, 58550-58554)
58550 Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less;
58552 with removal of tube(s) and/or ovary(s)
58553  Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;  
58554  with removal of tube(s) and/or ovary(s)  
58555  Hysteroscopy, diagnostic (separate procedure)  
58558  Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D&C  
58559  with lysis of intrauterine adhesions (any method)  
58560  with division or resection of intrauterine septum (any method)  
58561  with removal of leiomyomata  
58562  with removal of impacted foreign body  
58563  with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)  
58565  with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants  
(Do not report 58565 in conjunction with 58555 or 57800)  
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;

58951 with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy

58952 with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)

58953 Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;

58954 with pelvic lymphadenectomy and limited para-aortic lymphadenectomy

58955 Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;

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 (Report required)
59150 Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy
59151 with salpingectomy and/or oophorectomy
59160 Curettage, postpartum

INTRODUCTION

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

REPAIR

59300 Episiotomy or vaginal repair, by other than attending
59320 Cerclage of cervix, during pregnancy; vaginal
59325 abdominal
59350 Hysterorrhaphy of ruptured uterus

VAGINAL DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

59400 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and (inpatient and outpatient) postpartum care (total, all-inclusive, "global" care)
59409 Vaginal delivery only (with or without episiotomy and/or forceps); (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)
59410 including (inpatient and outpatient) postpartum care
59412 External cephalic version, with or without tocolysis
59414 Delivery of placenta (separate procedure)
(For antepartum care only, see 59425, 59426 or appropriate E/M code(s))
(For 1-3 antepartum care visits, see appropriate E/M code(s))
59425 Antepartum care only; 4-6 visits
59426 7 or more visits
(For 6 or less antepartum encounters, see code 59425)

Note: Antepartum services will no longer require prorated charges. This applies to all prenatal care providers, including those enrolled in the MOMS program. Providers should bill one unit of the appropriate antepartum code after all antepartum care has been rendered using the last antepartum visit as the date of service. Only one antepartum care code will be reimbursed per pregnancy.
59430  Postpartum care only (outpatient) (separate procedure)

**CESAREAN DELIVERY**

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

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

59515  including (inpatient and outpatient) postpartum care

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

**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 (Cl-C2) puncture; without injection (separate
       procedure)
61055   with injection of medication or other substance for diagnosis or treatment
61070  Puncture of shunt tubing or reservoir for aspiration or injection procedure
       (For radiological supervision and interpretation, use 75809)

TWIST DRILL, BURR HOLE(S) OR 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
61315  intracerebellar
61313  Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural
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 recontouring with multiple osteotomies and bone autografts (eg, barrel-stave procedure) (includes obtaining grafts)
61563 Excision, intra- and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); without optic nerve decompression (Report required)
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 **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.

**APPRAOCH PROCEDURES**

61580 Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration

61581 extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy

61582 extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa

61583 intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa

61584 Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); without orbital exenteration

61585 with orbital exenteration

61586 Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft

61590 Infratemporal pre-auricular approach to middle cranial fossa (parapharyngeal space, infratemporal and midline skull base, nasopharynx), with or without disarticulation of the mandible, including parotidectomy, craniotomy, decompression and/or mobilization of the facial nerve and/or petrous carotid artery

61591 Infratemporal post-auricular approach to middle cranial fossa (internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, infratemporal fossa) including mastoidectomy, resection of sigmoid sinus, with or without decompression and/or mobilization of contents of auditory canal or petrous carotid artery

61592 Orbitocranial zygomatic approach to middle cranial fossa (cavernous sinus and carotid artery, clivus, basilar artery or petrous apex) including osteotomy of zygoma, craniotomy, extra- or intradural elevation of temporal lobe

61595 Transtemporal approach to posterior cranial fossa, jugular foramen or midline skull base, including mastoidectomy, decompression of sigmoid sinus and/or facial nerve, with or without mobilization

61596 Transcochlear approach to posterior cranial fossa, jugular foramen or midline skull base, including labyrinthectomy, decompression, with or without mobilization of facial nerve and/or petrous carotid artery
61597 Transcondylar (far lateral) approach to posterior cranial fossa, jugular foramen or midline skull base including occipital condylectomy, mastoidectomy, resection of Cl-C3 vertebral body(s), decompression of vertebral artery, with or without mobilization

61598 Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus

DEFINITIVE PROCEDURES

61600 Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; extradural

61601 intradural, including dural repair, with or without graft

61605 Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural

61606 intradural, including dural repair, with or without graft

61607 Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural

61608 intradural, including dural repair, with or without graft

61610 with repair by anastomosis or graft

(List separately in addition to primary procedure)

61611 Transection or ligation, carotid artery in petrous canal; without repair

(List separately in addition to primary procedure)

61612 with repair by anastomosis or graft

(List separately in addition to primary procedure)

(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 Cl-C3 vertebral bodies; extradural

61616 intradural, including dural repair, with or without graft

REPAIR AND/OR RECONSTRUCTION OF SURGICAL DEFECTS OF SKULL BASE

61618 Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by free tissue graft (eg, pericranium, fascia, tensor fascia lata, adipose tissue, homologous or synthetic grafts)

61619 by local or regionalized vascularized pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle)
ENDOVASCULAR THERAPY

61623  Endovascular temporary balloon arterial occlusion, head or neck (extracranial/intracranial) including selective catheterization of vessel to be occluded, positioning and inflation of occlusion balloon, concomitant neurological monitoring, and radiologic supervision and interpretation of all angiography required for balloon occlusion and to exclude vascular injury post occlusion
(See also 37204)

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
      (Report required)

61635  Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed
      (Report required)
(61630 and 61635 include all selective vascular catheterization of the target vascular family, all diagnostic imaging for arteriography of the target vascular family, and all related radiological supervision and interpretation. When diagnostic arteriogram (including imaging and selective catheterization) confirms the need for angioplasty or stent placement, 61630 and 61635 are inclusive of these services. If angioplasty or stenting are not indicated, then the appropriate codes for selective catheterization and imaging should be reported in lieu of 61630 and 61635)

61640  Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel
      (Report required)

61641  each additional vessel in same vascular family (Report required)
      (List separately in addition to primary procedure)

61642  each additional vessel in different vascular family (Report required)
      (List separately in addition to primary procedure)
      (Use 61641 and 61642 in conjunction with 61640)
(61640, 61641, 61642 include all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, postdilatation angiography, and fluoroscopic guidance for the balloon dilatation)

SURGERY FOR ANEURYSM, ARTERIOVENOUS MALFORMATION OR VASCULAR DISEASE

Includes craniotomy when appropriate for procedure.
61680  Surgery of intracranial arteriovenous malformation; supratentorial, simple  
61682  supratentorial, complex  
61684  infratentorial, simple  
61686  infratentorial, complex  
61690  dural, simple  
61692  dural, complex  
61697  Surgery of complex intracranial aneurysm, intracranial approach; carotid  
        circulation  
        (61697, 61698 involve aneurysms that are larger than 15 mm or with  
        calcification of the aneurysm neck, or with incorporation of normal vessels into  
        the aneurysm neck, or a procedure requiring temporary vessel occlusion,  
        trapping or cardiopulmonary bypass to successfully treat the aneurysm)  
61700  Surgery of simple intracranial aneurysm, intracranial approach; carotid  
        circulation  
61702  vertebrobasilar circulation  
61703  Surgery of intracranial aneurysm, cervical approach by application of occluding  
        clamp to cervical carotid artery (Selverstone-Crutchfield type)  
61705  Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by  
        intracranial and cervical occlusion of carotid artery  
61708  by intracranial electrothrombosis  
61710  by intra-arterial embolization, injection procedure, or balloon catheter  
61711  Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical)  
        arteries  

**STEREOTAXIS**  

Coverage for 61781-61783 Stereotactic Computer-Assisted Volumetric  
(Navigational) Procedures is allowed only under the following conditions:  

Procedure to be performed as a pre-surgical assessment and/or intraoperative  
assessment, in preparation for, and execution of planned craniotomy (CPT codes  
61304-61576), along with a diagnosis of arteriovenous malformation of brain,  
malignant or benign neoplasm of the brain, or intractable epilepsy.  

61720  Creation of lesion by stereotactic method, including burr hole(s) and localizing  
        and recording techniques, single or multiple stages; globus pallidus or thalamus  
61735  subcortical structure(s) other than globus pallidus or thalamus  
61750  Stereotactic biopsy, aspiration, or excision, including burr hole(s), for  
        intracranial lesion;  
61751  with computed tomography and/or magnetic resonance guidance  
61760  Stereotactic implantation of depth electrodes into the cerebrum for long term  
        seizure monitoring
61770  Stereotactic localization, including burr hole(s); with insertion of catheter(s) or probe(s) for placement of radiation source

61781  Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to primary procedure)

61782  cranial, extradural
       (List separately in addition to primary procedure)

61783  spinal
       (List separately in addition to primary procedure)

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

61791  trigeminal medullary tract (Report required)

STEREOTACTIC RADIOSURGERY (CRANIAL)

61796  Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion
       (Do not report 61796 more than once per course of treatment)
       (Do not report 61796 in conjunction with 61798)

61797  each additional cranial lesion, simple
       (List separately in addition to primary procedure)
       (Use 61797 in conjunction with 61796, 61798)
       (For each course of treatment, 61797 and 61799 may be reported no more than once per lesion. Do not report any combination of 61797 and 61799 more than 4 times for entire course of treatment regardless of number of lesions treated)

61798  1 complex cranial lesion
       (Do not report 61798 more than once per course of treatment)
       (Do not report 61798 in conjunction with 61796)

61799  each additional cranial lesion, complex
       (List separately in addition to primary procedure)
       (Use 61799 in conjunction with 61798)
       (For each course of treatment, 61797 and 61799 may be reported no more than once per lesion. Do not report any combination of 61797 and 61799 more than 4 times for entire course of treatment regardless of number of lesions treated)

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

NEUROSTIMULATORS (INTRACRANIAL)

Codes 61850-61888 apply to both simple and complex neurostimulators. For initial or subsequent electronic analysis and programming of neurostimulator pulse generators, see codes 95970-95975.
Microelectrode recording, when performed by the operating surgeon in association with implantation of neurostimulator electrode arrays, is an inclusive service and should not be reported separately. If another physician participates in neurophysiological mapping during a deep brain stimulator implantation procedure, this service may be reported by the other physician with codes 95961-95962.

61850  Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical
61860  Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral; cortical
61863  Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array

61864  each additional array
      (List separately in addition to primary procedure)
      (Use 61864 in conjunction with 61863)

61867  Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array

61868  each additional array
      (List separately in addition to primary procedure)
      (Use 61868 in conjunction with 61867)

61870  Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical
61880  Revision or removal of intracranial neurostimulator electrodes
61885  Incision or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array

61886  with connection to two or more electrode arrays

61888  Revision or removal of cranial neurostimulator pulse generator or receiver
      (Do not report 61888 in conjunction with 61885 or 61886 for the same pulse generator)

**REPAIR**

62000  Elevation of depressed skull fracture; simple, extradural
62005  compound or comminuted, extradural
62010  with repair of dura and/or debridement of brain
62100  Craniotomy for repair of dural/cerebrospinal fluid leak, including surgery for rhinorrhea/otorrhea
62115  Reduction of craniomegalic skull (eg, treated hydrocephalus); not requiring bone grafts or cranioplasty

62117  requiring craniotomy and reconstruction with or without bone graft
       (includes obtaining grafts)
62120  Repair of encephalocele, skull vault, including cranioplasty
62121  Craniotomy for repair of encephalocele, skull base
62140  Cranioplasty for skull defect; up to 5 cm diameter
62141  larger than 5 cm diameter
62142  Removal of bone flap or prosthetic plate of skull
62143  Replacement of bone flap or prosthetic plate of skull
62145  Cranioplasty for skull defect with reparative brain surgery
62146  Cranioplasty with autograft (includes obtaining bone grafts); up to 5 cm diameter
62147  larger than 5 cm diameter
62148  Incision and retrieval of subcutaneous cranial bone graft for cranioplasty
   (List separately in addition to primary procedure)
   (Use 62148 in conjunction with codes 62140-62147)

**NEUROENDOSCOPY**

Surgical endoscopy always includes diagnostic endoscopy.

62160  Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage
   (List separately in addition to primary procedure)
   (Use 62160 only in conjunction with codes 61107, 61210, 62220, 62223, 62225 or 62230)
62161  Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter)
62162  with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage
62163  with retrieval of foreign body
62164  with excision of brain tumor, including placement of external ventricular catheter for drainage
62165  with excision of pituitary tumor, transnasal or trans-sphenoidal approach

**CEREBROSPINAL FLUID (CSF) SHUNT**

(For codes 62220, 62223, 62225, 62230, 62258, for intracranial neuroendoscopic ventricular catheter placement, use 62160)

62180  Ventriculocisternostomy (Torkildsen type operation)
62190  Creation of shunt; subarachnoid/subdural-atrial, -jugular, -auricular
62192  subarachnoid/subdural-peritoneal, -pleural, -other terminus
62194  Replacement or irrigation, subarachnoid/subdural catheter
62200  Ventriculocisternostomy, third ventricle
62201  stereotactic, neuroendoscopic method
62220  Creation of shunt; ventriculo-atrial, -jugular, -auricular
62223  ventriculo-peritoneal, -pleural, -other terminus
62225  Replacement or irrigation, ventricular catheter
62230  Replacement or revision of cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system
62252  Reprogramming of programmable cerebrospinal fluid shunt
62256  Removal of complete cerebrospinal fluid shunt system; without replacement 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, 62310-62319. Fluoroscopic guidance and localization is reported by code 77003, unless a formal contrast study (myelography, epidurography, or arthrography) is performed, in which case the use of fluoroscopy is included in the supervision and interpretation codes.

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; subarachnoid
62281 epidural, cervical or thoracic
62282 epidural, lumbar, sacral (caudal)
62284 Injection procedure for myelography and/or computed tomography, lumbar (other than C1-C2 and posterior fossa)
62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar
(Do not report 62287 in conjunction with 62267, 62290, 62311, 77003, 77012, 72295, when performed at same level)
62290 Injection procedure for discography, each level; lumbar
62291 cervical or thoracic
62292 Injection procedure for chemonucleolysis, including discography, intervertebral disk, single or multiple levels, lumbar
62294 Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal
62302 Myelography via lumbar injection, including radiological supervision and interpretation; cervical
62303 thoracic
62304 lumbosacral
62305 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)
62310 Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
62311 lumbar or sacral (caudal)
62318 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
62319 lumbar or sacral (caudal)

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

RESERVOIR/PUMP IMPLANTATION

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

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

(For bilateral procedure report 63020, 63030, 63035, 63040, 63042, 63043, 63044 with modifier 50)
63001 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), one or two vertebral segments; cervical
63003 thoracic
63005 lumbar, except for spondylolisthesis
63011 sacral
63012 Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63015 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg. spinal stenosis), more than 2 vertebral segments; cervical
63016 thoracic
63017 lumbar
63020  Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63030   1 interspace, lumbar
63035  each additional interspace, cervical or lumbar
(List separately in addition to primary procedure)
(Use 63035 in conjunction with 63020-63030)
63040  Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; cervical
63042   lumbar
63043  each additional cervical interspace
(List separately in addition to primary procedure)
(Use 63043 in conjunction with 63040)
63044  each additional lumbar interspace
(List separately in addition to primary procedure)
(Use 63044 in conjunction with code 63042)
63045  Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; cervical
63046   thoracic
63047   lumbar
63048  each additional segment, cervical thoracic or lumbar
(List separately in addition to primary procedure)
(Use 63048 in conjunction with codes 63045-63047)
63050  Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments;
63051   with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)
(Do not report 63050 or 63051 in conjunction with 22600, 22614, 22840-22842, 63001, 63015, 63045, 63048, 63295 for the same vertebral segment(s))

TRANSPEDICULAR OR COSTOVERTEBRAL APPROACH FOR POSTEROLATERAL EXTRADURAL EXPLORATION/DECOMPRESSION

63055  Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disk), single segment; thoracic
63056   lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disk)
63057  each additional segment, thoracic or lumbar
(List separately in addition to primary procedure)
(Use 63057 in conjunction with codes 63055, 63056)
63064  Costovertebral approach with decompression of spinal cord or nerve root(s),
(eg, herniated intervertebral disk), thoracic; single segment
63066  each additional segment
   (List separately in addition to primary procedure)
   (Use 63066 in conjunction with code 63064)

ANTERIOR OR ANTEROLATERAL APPROACH FOR EXTRADURAL EXPLORATION/DECOMPRESSION

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

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

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

LATERAL EXTRACAVITARY APPROACH FOR EXTRADURAL EXPLORATION/DECOMPRESSION

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

INCISION

63170  Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic or thoracolumbar
63172  Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid space
63173  to peritoneal or pleural space
63180  Laminectomy and section of dentate ligaments, with or without dural graft, cervical; one or two segments
63182  more than two segments
63185  Laminectomy with rhizotomy; one or two segments
63190  more than two segments
63191  Laminectomy with section of spinal accessory nerve
   (For bilateral procedure, use modifier -50)
63194  Laminectomy with cordotomy, with section of one spinothalamic tract, one stage; cervical
63195  thoracic
63196 Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage; cervical
63197  
63198 Laminectomy with cordotomy, with section of both spinothalamic tracts, two stages within 14 days; cervical **(Report required)**
63199  thoracic **(Report required)**
63200 Laminectomy, with release of tethered spinal cord, lumbar

**EXCISION BY LAMINECTONY OF LESION OTHER THAN HERNIATED DISK**

63250 Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical
63251  thoracic
63252  thoracolumbar
63265 Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
63266  thoracic
63267  lumbar
63268  sacral
63270 Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical
63271  thoracic
63272  lumbar
63273  sacral
63275 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical
63276  extradural, thoracic
63277  extradural, lumbar
63278  extradural, sacral
63280  intradural, extramedullary, cervical
63281  intradural, extramedullary, thoracic
63282  intradural, extramedullary, lumbar
63283  intradural, sacral
63285  intradural, intramedullary, cervical
63286  intradural, intramedullary, thoracic
63287  intradural, intramedullary, thoracolumbar
63290  combined extradural-intradural lesion, any level
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) (Report required)

63610  Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery (Report required)

63615  Stereotactic biopsy, aspiration, or excision of lesion spinal cord (Report required)

STEREOTACTIC RADIOSURGERY (SPINAL)

63620  Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion
   (Do not report 63620 more than once per course of treatment)

63621  each additional spinal lesion
   (List separately in addition to primary procedure)
   (Report 63621 in conjunction with 63620)
   (For each course of treatment, 63621 may be reported no more than once per lesion. Do not report 63621 more than 2 times for entire course of treatment regardless of number of lesions treated)

NEUROSTIMULATORS (SPINAL)
Codes 63650-63688 apply to both simple and complex neurostimulators. For initial or subsequent electronic analysis and programming of neurostimulator pulse generators, see codes 95970-95975.

Codes 63650, 63655, and 63661-63664 describe the operative placement, revision, or removal of the spinal neurostimulator system components to provide spinal electrical stimulation. A neurostimulator system includes an implanted neurostimulator, external controller, extension, and collection of contacts. Multiple contacts or electrodes (4 or more) provide the actual electrical stimulation in the epidural space.

For percutaneously placed neurostimulator systems (63650, 63661, 63663) the contacts are on a catheter-like lead. An array defines the collection of contacts that are on one catheter.

For systems placed via an open surgical exposure (63655, 63662, 63664) the contacts are on a plate or paddle-shaped surface.

63650  Percutaneous implantation of neurostimulator electrode array, epidural
63655  Laminectomy for implantation of neurostimulator electrodes plate/paddle, epidural
63661  Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63662  Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63663  Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
          (Do not report 63663 in conjunction with 63661, 63662 for the same spinal level)
63664  Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
          (Do not report 63664 in conjunction with 63661, 63662 for the same spinal level)
63685  Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
          (Do not report 63685 in conjunction with 63688 for the same pulse generator or receiver)
63688  Revision or removal of implanted spinal neurostimulator pulse generator or receiver

**REPAIR**

(Do not use modifier –63 in conjunction with 63700-63706)

63700  Repair of meningocele; less than 5 cm diameter
63702  larger than 5 cm diameter
63704  Repair of myelomeningocele; less than 5 cm diameter
63706  larger than 5 cm diameter
63707  Repair of dural/cerebrospinal fluid leak, not requiring laminectomy
63709  Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy
63710  Dural graft, spinal

SHUNT, SPINAL CSF

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

EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM

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

SOMATIC NERVES

64400  Injection, anesthetic agent; trigeminal nerve, any division or branch
64402  facial nerve
64405  greater occipital nerve
64408  vagus nerve
64410  phrenic nerve
64412  spinal accessory nerve
64413  cervical plexus
64415  brachial plexus, single
64416  brachial plexus, continuous infusion by catheter (including catheter placement)
64417  axillary nerve
64418  suprascapular nerve
64420  intercostal nerve, single
64421  intercostal nerves, multiple, regional block
64425  ilioinguinal, iliohypogastric nerves
64430  pudendal nerve
64435  paracervical (uterine) nerve
64445  sciatic nerve, single
64446  sciatic nerve, continuous infusion by catheter, (including catheter placement)
64447  femoral nerve, single
64448  femoral nerve, continuous infusion by catheter, (including catheter placement)
64449  lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)
64450  other peripheral nerve or branch
64455  Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma) (Do not report 64455 in conjunction with 64632)
64479  Injection(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)
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 (excludes sacral nerve) (Do not report 64555 in conjunction with 64566)
64555  peripheral nerve (excludes sacral nerve) (Do not report 64555 in conjunction with 64566)
64561  sacral nerve (transforaminal placement) including image guidance, if performed (Report required)
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) (Report required)
64585  Revision or removal of peripheral neurostimulator electrode array
64590  Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling (Do not report 64590 in conjunction with 64595)
64595  Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver

DESTRUCTION BY NEUROLYTIC AGENT (EG, CHEMICAL, THERMAL, ELECTRICAL, RADIOFREQUENCY)
Codes 64600-64681 include the injection of other therapeutic agents (eg, corticosteroids).

SOMATIC NERVES

64600 Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
64605 second and third division branches at foramen ovale
64610 second and third division branches at foramen ovale under radiologic monitoring
64611 Chemodenervation of parotid and submandibular salivary glands, bilateral
64612 Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)
64615 muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
64616 neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis
64617 larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed
64620 Destruction by neurolytic agent; intercostal nerve
64630 Destruction by neurolytic agent; pudendal nerve
64632 plantar common digital nerve
(Do not report 64632 in conjunction with 64455)
64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634 cervical or thoracic, each additional facet joint
(List separately in addition to primary procedure)
(Use 64634 in conjunction with 64633)
64635 lumbar or sacral, single facet joint
64636 lumbar or sacral, each additional facet joint
(List separately in addition to primary procedure)
(Use 64636 in conjunction with 64635)
(Do not report 64633-64636 in conjunction with 77003, 77012)
(For bilateral procedure, report 64633-64636 with modifier 50)
64640 other peripheral nerve or branch
64642 Chemodenervation of one extremity; 1-4 muscle(s)
64643 each additional extremity; 1-4 muscle(s) (List separately in addition to code for primary procedure)
64644 Chemodenervation of one extremity; 5 or more muscle(s)
64645 each additional extremity; 5 or more muscle(s) (List separately in addition to code for primary procedure)
64646 Chemodenervation of trunk muscle(s); 1-5 muscle(s)
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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 (Report required)
   (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 (Report required)
64742 facial nerve, differential or complete (Report required)
64744 greater occipital nerve
64746 phrenic nerve
64755 vagus nerve limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy)
64760 vagus nerve (vagotomy), abdominal (Report required)
64763 Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy
64766 Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy
64771 Transection or avulsion of other cranial nerve, extradural
   (For procedures 64763, 64766, for bilateral procedure, use modifier -50)
64772 Transection or avulsion of other spinal nerve, extradural

EXCISION

SOMATIC NERVES

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

SYMPATHETIC NERVES

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

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

NEURORRHAPHY
64831  Suture of digital nerve, hand or foot; one nerve
64832  each additional digital nerve
   (List separately in addition to primary procedure)
   (Use 64832 in conjunction with 64831)
64834  Suture of one nerve; hand or foot, common sensory nerve
64835  median motor thenar
64836  ulnar motor
64837  Suture of each additional nerve, hand or foot
   (List separately in addition to primary procedure)
   (Use 64837 in conjunction with 64834-64836)
64840  Suture of posterior tibial nerve
64856  Suture of major peripheral nerve, arm or leg, except sciatic; including
   transposition
64857  without transposition
64858  Suture of sciatic nerve
64859  Suture of each additional major peripheral nerve
   (List separately in addition to primary procedure)
   (Use 64859 in conjunction with 64856, 64857)
64861  Suture of; brachial plexus
64862  lumbar plexus
64864  Suture of facial nerve; extracranial
64865  infratemporal, with or without grafting
64866  Anastomosis; facial-spinal accessory
64868  facial-hypoglossal
64872  Suture of nerve; requiring secondary or delayed suture
   (List separately in addition to primary neurorrhaphy)
64874  requiring extensive mobilization, or transposition of nerve
   (List separately in addition to code for nerve suture)
64876  requiring shortening of bone of extremity (Report required)
   (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)  
(Report required)
65130  Insertion of ocular implant secondary; after evisceration, in scleral shell
65135  after enucleation, muscles not attached to implant
65140  after enucleation, muscles attached to implant
65150  Reinsertion of ocular implant; with or without conjunctival graft
65155  with use of foreign material for reinforcement and/or attachment of muscles to implant
65175  Removal of ocular implant

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 (Report required)
65770  Keratoprosthesis
65771  Radial keratotomy
65772  Corneal relaxing incision for correction of surgically induced astigmatism
65775  Corneal wedge resection for correction of surgically induced astigmatism (Report required)

65778  Placement of amniotic membrane on the ocular surface; without sutures
65779  single layer, sutured
65780  Ocular surface reconstruction; amniotic membrane transplantation, multiple layers
65781  limbal stem allograft (eg, cadaveric or living donor)
65782  limbal conjunctival autograft (includes obtaining graft)

ANTERIOR CHAMBER

INCISION

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

REMOVAL

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

INTRODUCTION

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

ANTERIOR SCLERA

EXCISION

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

AQUEOUS SHUNT

66179  Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft
66180  with graft
66184  Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft
66185  with graft

REPAIR OR REVISION

66220  Repair of scleral staphyloma; without graft (Report required)
66225  with graft (Report required)
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)
       (Report required)

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, 67112)

**66999** Unlisted procedure, anterior segment, eye

**POSTERIOR SEGMENT**

**VITREOUS**

**67005** Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal

**67010** subtotal removal with mechanical vitrectomy

**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; 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, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid

67105  photocoagulation with or without drainage of subretinal fluid

67107  Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, 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)

67112  by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques

(For use of ophthalmic endoscope with 67112, use 66990)

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

67115  Release of encircling material (posterior segment)

67120  Removal of implanted material, posterior segment; extraocular

67121  intraocular

PROPHYLAXIS

Codes 67141, 67145, 67208-67220, 67227, 67228, 67229 include treatment at one or more sessions that may occur at different encounters. These codes should be reported once during a defined treatment period.
Repetitive services. The services listed below are often performed in multiple sessions
or groups of sessions. The methods of reporting vary.

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

67141 Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration)
without drainage, one or more sessions; cryotherapy, diathermy
67145 photocoagulation (laser or xenon arc)

DESTRUCTION

67208 Destruction of localized lesion of retina (eg, macular edema, tumors) one or
more sessions; cryotherapy, diathermy
67210 photocoagulation
67218 radiation by implantation of source (includes removal of source)
67220 Destruction of localized lesion of choroid (eg, choroidal neovascularization);
photocoagulation (eg, laser), one or more sessions
67221 photodynamic therapy (includes intravenous infusion)
67225 photodynamic therapy, second eye, at single session
(List separately in addition to primary eye treatment)
(Use 67225 in conjunction with code 67221)
67227 Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy),
one or more sessions; cryotherapy, diathermy
67228 Treatment of extensive or progressive retinopathy, one or more sessions; (eg,
diabetic retinopathy), photocoagulation
67229 preterm infant (less than 37 weeks gestation at birth), performed from birth
up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or
cryotherapy
(For bilateral procedure, use modifier 50)

POSTERIOR SCLERAL

REPAIR

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

OTHER PROCEDURES

67299 Unlisted procedure, posterior segment

OCULAR ADNEXA

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

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

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

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

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

OTHER PROCEDURES

67399 Unlisted procedure, extraocular muscle

ORBIT

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

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

EYELIDS

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

EXCISION, DESTRUCTION
Codes for removal of lesion include more than skin (i.e., involving lid margin, tarsus, and/or palpebral conjunctiva)
67800 Excision of chalazion; single
67801 multiple, same lid
67805 multiple, different lids
67808 under general anesthesia and/or requiring hospitalization, single or multiple
67810 Incisional biopsy of eyelid skin including lid margin
67820 Correction of trichiasis; epilation, by forceps only
67825 epilation by other than forceps (eg, by electrosurgery, cryotherapy, laser surgery)
67830 incision of lid margin
67835 incision of lid margin, with free mucous membrane graft
67840 Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure
67850 Destruction of lesion of lid margin (up to 1 cm) (Report required)

TARSORRHAPHY

67875 Temporary closure of eyelids by suture (eg, Frost suture)
67880 Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;
67882 with transposition of tarsal plate

REPAIR (BROW PTOSIS, BLEPHAROPTOSIS, LID RETRACTION, ECTROPION, ENTROPION)

67900 Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901 Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902 (tarso) levator resection or advancement, internal approach
67904 (tarso) levator resection or advancement, external approach
67906 superior rectus technique with fascial sling (includes obtaining fascia)
67908 conjunctivo-tarso-Muller’s muscle-levator resection (Fasanella-Servat type)
67909 Reduction of overcorrection of ptosis
67911 Correction of lid retraction
67912 Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)
67914 Repair of ectropion; suture
67915 thermocauterization
67916 excision tarsal wedge
67917 extensive (eg, tarsal strip operations)
67921 Repair of entropion; suture
67922 thermocauterization
67923 excision tarsal wedge
67924 extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)

RECONSTRUCTION
Codes for blepharoplasty involve more than skin (ie, involving lid margin, tarsus, and/or palpebral conjunctiva)

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

OTHER PROCEDURES
67999  Unlisted procedure, eyelids

CONJUNCTIVA

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

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

INJECTION
68200  Subconjunctival injection

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

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

LACRIMAL SYSTEM

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

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

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

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

68801  Dilation of lacrimal punctum, with or without irrigation
68810  Probing of nasolacrimal duct, with or without irrigation;
       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

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
       (Report required)
69205  with general anesthesia
69220  Debridement, mastoidectomy cavity, simple (eg, routine cleaning)
69222  Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)

**REPAIR**

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 (Report required)
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
69647 with intact or reconstructed wall, with ossicular chain reconstruction
69648 radical or complete, with ossicular chain reconstruction
69649 with intact or reconstructed canal wall, with ossicular chain reconstruction
69650 Stapes mobilization
69660 Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with
or without use of foreign material;
69661 with footplate drill out
69662 Revision of stapedectomy or stapedotomy
69666 Repair oval window fistula
69667 Repair round window fistula
69670 Mastoid obliteration (separate procedure)
69676 Tympanic neurectomy
(For bilateral procedure, use modifier -50)

OTHER PROCEDURES
69700 Closure postauricular fistula, mastoid (separate procedure)
69710  Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone
(Replacement procedure includes removal of old device)
69711  Removal or repair of electromagnetic bone conduction hearing device in temporal bone *(Report required)*
69714  Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy  
  with mastoidectomy
69715  Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy  
  with mastoidectomy
69717  Decompression facial nerve, intratemporal; lateral to geniculate ganglion  
  including medial to geniculate ganglion
69740  Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion  
  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 *(Report required)*

**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 *(Report required)*
69955  Total facial nerve decompression and/or repair (may include graft)
69960  Decompression internal auditory canal
69970  Removal of tumor, temporal bone

**OTHER PROCEDURES**

69979  Unlisted procedure, temporal bone, middle fossa approach