NEW YORK STATE
MEDICAID PROGRAM

PHYSICIAN

FEE SCHEDULE

Table of Contents

G. SURGERY:

H. RADIOLOGY:

I. APPENDIX A:

GENERAL INFORMATION

This Medical Fee Schedule applies to Medicine, Surgery, Anesthesia and Radiology Services. Underlined procedure codes require Prior Approval before services are rendered.

1. **OSTEOPATHIC PHYSICIANS:** The Medical Fee Schedule for physicians is applicable to services provided by osteopathic physicians.

2. **MULTIPLE CALLS:** If an individual patient is seen on more than one occasion during a single day, the fee for each visit may be allowed.

3. **CHARGES FOR DIAGNOSTIC PROCEDURES:** Charges for special diagnostic procedures which are not considered to be a routine part of an attending physician's or consultant's examination (eg, pregnancy test, diagnostic X-ray, lumbar puncture) are reimbursable in addition to the usual physician's visit fee.

4. **REFERRAL:** A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. Initial evaluation and subsequent services are designated as listed in LEVELS OF E/M SERVICE.

5. **CONSULTATION:** Consultation is to be distinguished from referral. REFERRAL is the transfer of the patient from one physician to another for definitive treatment. CONSULTATION is advice and opinion from an accredited physician specialist called in by the attending practitioner in regard to the further management of the patient by the attending practitioner.

   Consultation fees are applicable only when examinations are provided by an accredited physician specialist within the scope of his specialty upon request of the authorizing agency or of the attending practitioner who is treating the medical problem for which consultation is required.The attending practitioner must certify that he requested such consultation and that it was incident and necessary to his further care of the patient.

   When the consultant physician assumes responsibility for a portion of patient management, he will be rendering concurrent care (use appropriate level of Evaluation and Management codes). If he has had the case transferred or referred to him, he should then use the appropriate codes for services rendered (eg, visits, procedures)on and subsequent to the date of transfer.

6. **PROCEDURE NOT INCLUDED:** Each public agency may determine, on an individual basis, fees for services or procedures not included in the Medical Fee Schedule. The value and appropriateness of services not specifically listed in this fee schedule will be determined "By Report". Claims for these services will be manually reviewed by medical professional staff. The MMIS procedure codes to be utilized when submitting claims for such unlisted services may be found at the end of each section.

7. **BY REPORT:** A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are: complexity of symptoms, final diagnosis, pertinent physical findings (such as size, locations, and number of lesions(s), if appropriate), diagnostic and therapeutic procedures (including major and supplementary surgical procedures, if appropriate), concurrent problems, and follow-up care.

   When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service must be furnished in addition to the time, skill and equipment necessitated. Appropriate documentation (eg, procedure description, itemized invoices, etc.) should accompany all claims submitted.

   Itemized invoices must document acquisition cost, the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations.

8. **PAYMENT IN FULL:** Fees paid in accordance with the allowances in the Medical Fee Schedule shall be considered full payment for services rendered. No additional charge shall be made by a physician.

9. **FEES:** Listed fees are the maximum reimbursable Medicaid fees**.**

10. **PRESCRIBER WORKSHEET:** Enteral formula requires voice interactive telephone prior authorization from the Medicaid program. The prescriber must inititate the authorization through this system. The worksheet specifies the questions asked on the voice interactive telephone system and must be maintained in the patient's clinical record. The worksheet can be found on the Provider Communication link. eMedNY : Provider Manuals : Physician Provider Communications

STATE DEPARTMENT OF HEALTH CONDITIONS FOR PAYMENTS

CONDITION FOR PAYMENT: Qualified physicians may be paid on a fee-for-service basis for direct care of patients when their salary/ compensation is not paid for purposes of providing direct patient care, i.e., when the salary/compensation is paid exclusively for activities such as teaching, various administrative duties (department heads, etc.) or for research.

Teaching physicians may bill for direct patient care services rendered while supervising a resident, provided that personal and identifiable services are provided to the patient in connection with the supervisory services; that the appropriate degree of documented supervision was provided; and that the teaching physicians are not salaried for patient care by the hospital.

CONDITIONS BARRING PAYMENT: Payment on a fee-for-service basis to a salaried/compensated physician may not be made when (1) any portion of the salary/compensation paid to such salaried/compensated physician is for direct care of patients, and (2) there is any prohibition for such payment in law, in the rules of particular hospital or in the contractual arrangement with the salaried/compensated physician or group.

MAXIMUM REIMBURSABLE FEE SCHEDULE: Payment for in-hospital surgical care will be limited to 80% of the fees as listed in the Surgery Section of the State Medical Fee Schedule when after-care is provided in the outpatient department. Payment for such after-care will be made on a per-visit basis to the hospital and to the outpatient physician (or to the hospital in his behalf) in accordance with prescribed procedures. (See modifier -54.)

In those instances where a patient is admitted to a hospital service which is covered by an approved training program and at the time of admission the patient is without a "private" physician, the attending physician assigned as "personal" physician to assume professional responsibility for the patient's care, is eligible for payment as per the Hospital Evaluation and Management codes.

If at the time of admission to a hospital service covered by an approved training program, the patient has a "private" physician who accepts continuing responsibility for the patient's care, that physician is eligible for payment as per the Hospital Evaluation and Management codes.

PHYSICIAN SERVICES PROVIDED IN HOSPITALS

When non-salaried/non-compensated physicians, either individually or as a group, provide services to either outpatients or inpatients, payment will be made via the appropriate Evaluation and Management code.

Salaries/compensation of physicians employed by a hospital to provide patient care are included as hospital costs in determining inpatient and outpatient reimbursement rates and therefore no separate payments may be made to such physicians.

MMIS MODIFIERS

Under certain circumstances, the procedure code identifying a specific procedure or service must be expanded by two additional characters to further define or explain the nature of the procedure.

The circumstances under which such further description is required are detailed below along with the appropriate modifiers to be added to the basic code when the particular circumstance applies.

If more than one modifier is required, the "multiple modifier" code should be added to the basic procedure code number and other applicable modifiers shall be listed as part of the service description.

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

-24 Unrelated Evaluation and Management Service by the Same Practitioner During a Postoperative Period:
The practitioner may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier -24 to the appropriate level of E/M service. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Practitioner on the Day of a Procedure: (Effective 10/1/92) The practitioner may need to indicate that on the day a procedure or service identified by an MMIS code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier -25 to the appropriate level of E/M service. **NOTE:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-26 Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier –26 to the usual procedure number. (Reimbursement will not exceed 40% of the maximum State Medical Fee Schedule amount.)

-TC Technical Component: Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier -TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. (Reimbursement will not exceed 60% of the maximum State Medical Fee Schedule amount.)

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

-50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral medical procedures and surgical procedures requiring a separate incision that are performed at the same operative session, or bilateral x-ray examinations should be identified by the appropriate procedure code describing the first procedure. To indicate a bilateral procedure was done add modifier -50 to the procedure number. (Reimbursement will not exceed 150% of the maximum State Medical Fee Schedule amount for medicine and surgery services or 160% of the maximum State Medical Fee Schedule amount for radiology services. 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 or postoperative management is to be provided in an outpatient department, surgical services may be identified by adding the modifier -54 to the usual procedure number. (Reimbursement will not exceed 80% of the maximum State Medical 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 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 the modifier –63 to the procedure number.

Note: Unless otherwise designated, this modifier may only be appended to procedure/services listed in the 20000-69999 code series. Modifier –63 should not be appended to any codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Laboratory, or Medicine sections. (Reimbursement will not exceed 100% of the maximum State Medical 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 State Medical Fee Schedule amount.)

-76 Repeat X-ray Procedure: When a repeat X-ray examination of the same part and for the same illness is required for reasons other than technical or professional error in the original X-ray, it will be identified by adding modifier -76. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-77 Repeat Procedure By Another Physician (or Practitioner): The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier -77 to the repeated service. (Reimbursement will not exceed 100% of the maximum State Medical 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 State Medical 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 using the modifier -79 to the related procedure. (Reimbursement will not exceed 100% of the maximum State Medical 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 State Medical 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 State Medical Fee Schedule amount.)

-AJ Clinical Social Worker: To report services of a Certified Social Worker (CSW) under the direct supervision of an employing psychiatrist, modifier –AJ should be added to the appropriate procedure code listed below. (Reimbursement will not exceed the indicated amount.) 90804 ($13.50), 90806 ($27.00), 90846 ($7.20), 90847 ($7.20), 90849 ($7.20), 90853 ($7.20), 90857 ($7.20).

-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 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 State Medical Fee Schedule amount).

-EP Child/Teen Health Program (EPSDT Program): Service provided as part of the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program or Child/Teen Health Program will be identified by adding the modifier -EP to the usual procedure number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-FP Service Provided as Part of Family Planning Program: All Family Planning Services will be identified by adding the modifier -FP to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical 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 State Medical 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.) Add modifier –RT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed). **(Use modifier –50 when both sides done at same operative session.)**

-SL State Supplied Vaccine**:** (Used to identify administration of vaccine supplied by the Vaccine for Children's Program (VFC) for children under 19 years of age). When administering vaccine supplied by the state (VFC program), you **must** append modifier –SL State Supplied Vaccine to the procedure code number representing the vaccine administered. Omission of this modifier on claims for recipients under 19 years of age will cause your claim to deny. (Reimbursement will not exceed $17.85, the administration fee for the VFC program.)

-99 Multiple Modifiers: Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier -99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

MEDICINE SECTION

GENERAL INFORMATION AND RULES

1. **PRIMARY CARE:** Primary care is first-contact care, the type furnished to individuals when they enter the health care system. Primary care is comprehensive in that it deals with a wide range of health problems, diagnosis and modes of treatment. Primary care is continuous in that an ongoing relationship is established with the primary care practitioner who monitors and provides the necessary follow-up care and is coordinated by linking patients with more varied specialized services when needed. Consultations and care provided on referral from another practitioner is not considered primary care.

2. **CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES:** The Federal Health Care Finance Administration has mandated that all state Medicaid programs utilize the new Evaluation and Management coding as published in the American Medical Association's Physicians' Current Procedural Terminology.

   For the first time, a major section has been devoted entirely to E/M services. The new codes are more than a clarification of the old definitions; they represent a new way of classifying the work of practitioners. In particular, they involve far more clinical detail than the old visit codes. For this reason, it is important to treat the new codes as a new system and not make a one-for-one substitution of a new code number for a code number previously used to report a level of service defined as "brief", "limited", "intermediate", etc.

   The E/M section is divided into broad categories such as office visits, hospital visits and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of practitioner work varies by type of service, place of service, and the patient's status.

   The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined, eg, comprehensive history and comprehensive examination. (See levels of E/M services following for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified.

3. **DEFINITIONS OF COMMONLY USED E/M TERMS:** Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting.

NEW AND ESTABLISHED PATIENT: Solely for the purpose of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific code. A new patient is one who has not received any professional services from the practitioner or practitioners working in the same specialty within the same group within the past three years.

An established patient is one who has received professional services from the practitioner within the past three years.

In the instance where a practitioner is on call for or covering for another practitioner, the patient's encounter will be classified as it would have been by the practitioner who is not available.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

CHIEF COMPLAINT: A concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient's words.

CONCURRENT CARE: is the provision of similar services, eg, hospital visits, to the same patient by more than one practitioner on the same day. When concurrent care is provided, no special reporting is required. Modifier -75 has been deleted.

COUNSELING: Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- diagnostic results, impressions, and/or recommended diagnostic studies;
- prognosis;
- risks and benefits of management (treatment) options;
- instructions for management (treatment) and/or follow-up;
- importance of compliance with chosen management (treatment)options;
- risk factor reduction; and
- patient and family education.

FAMILY HISTORY: A review of medical events in the patient's family that includes significant information about:

- the health status or cause of death of parents, siblings, and children;
- specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review;
- diseases of family members which may be hereditary or place the patient at risk.

HISTORY OF PRESENT ILLNESS: A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors and associated signs and symptoms significantly related to the presenting problem(s).

NATURE OF PRESENTING PROBLEM: A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- Minimal - A problem that may not require the presence of the practitioner, but service is provided under the practitioner's supervision.
- Self-limited or Minor - A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status OR has a good prognosis with management/compliance.
- Low severity - A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
- Moderate severity - A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
- High severity - A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

PAST HISTORY: A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

- prior major illnesses and injuries;
- prior operations;
- prior hospitalizations;
- current medications;
- allergies (eg, drug, food);
- age appropriate immunization status;
- age appropriate feeding/dietary status.

SOCIAL HISTORY: An age appropriate review of past and current activities that include significant information about:

- martial status and/or living arrangements;
- current employment;
- occupational history;
- use of drugs, alcohol, and tobacco;
- level of education;
- sexual history;
- other relevant social factors.

SYSTEM REVIEW (REVIEW OF SYSTEMS): An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. The following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

TIME: The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions. The inclusion of time as an explicit factor beginning in 1992 is done to assist practitioners in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for practitioners to provide accurate estimates of the time spent face-to-face with the patient.

Intra-service times are defined as **face-to-face** time for office and other outpatient visits and as **unit/floor** time for hospital or other inpatient visits. This distinction is necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit.

A. **Face-to-face time (eg. office and other outpatient visits, office consultations and all psychiatry procedures):** For coding purposes, face-to-face time for these services is defined as only that time that the practitioner spends face-to-face with the patient and/or family. This includes the time in which the practitioner performs such tasks as obtaining a history, performing an examination, and counseling the patient.

Practitioners also spend time doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.

This non face-to-face time for office services - also called pre- and post-encounter time - is **not included** in the time component described in the E/M codes. However, the pre- and post face-to-face work associated with an encounter was included in calculating the total work of typical services.

Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit.

B. **Unit/floor time (hospital observation services, inpatient hospital care, initial and follow-up hospital consultations, nursing facility):** For reporting purposes, intra-service time for these services is defined as unit/floor time, which includes the time that the practitioner is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the practitioner establishes and/or reviews the patient's chart, examines the patient, writes notes and communicates with other professionals and the patient's family.

In the hospital, pre- and post-time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital.

This pre- and post-visit time is not included in the time component described in these codes. However, the pre- and post-work performed during the time spent off the floor or unit was included in calculating the total work of typical services.

Thus, the unit/floor time associated with the services described by any code is a valid proxy for the total work done before, during, and after the visit.

4A. **LEVELS OF E/M SERVICES*:*** Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are not interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.

The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services such as the determination of the need and/or location for appropriate care. Medical screening includes the history, examination, and medical decision-making required to determine the need and/or location for appropriate care and treatment of the patient (eg office and other outpatient setting, emergency department, nursing facility, etc.). The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health.

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are: history; examination; medical decision making; counseling; coordination of care; nature of presenting problem; and time.

The first three of these components (history, examination and medical decision making) are considered the **key** components in selecting a level of E/M services.

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter. The final component, time, has already been discussed in detail.

The actual performance of diagnostic tests/studies for which specific codes are available is **not** included in the levels of E/M services. Practitioner performance of diagnostic tests/studies for which specific codes are available should be reported separately, in addition to the appropriate E/M code.

4B. **INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE:**

i. IDENTIFY THE CATEGORY AND SUBCATEGORY OF SERVICE: Select from the categories and subcategories of codes available for reporting E/M services.

ii. REVIEW THE REPORTING INSTRUCTIONS FOR THE SELECTED CATEGORY OR SUBCATEGORY: Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Care', special instructions will be presented preceding the levels of E/M services.

iii. REVIEW THE LEVEL OF E/M SERVICE DESCRIPTORS AND EXAMPLES IN THE SELECTED CATEGORY OR SUBCATEGORY: The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are: history, examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time.

The first three of these components (ie, history, examination and medical decision making) should be considered the key components in selecting the level of E/M services. An exception to this rule is in the case of visits which consist predominantly of counseling or coordination of care (See vii.C.).

The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service.

iv. DETERMINE THE EXTENT OF HISTORY OBTAINED: The levels of E/M services recognize four types of history that are defined as follows:

- Problem Focused -- chief complaint; brief history of present illness or problem.
- Expanded Problem Focused -- chief complaint; brief history of present illness; problem pertinent system review.
- Detailed -- chief complaint; extended history of present illness; problem pertinent system review extended to include review of a limited number of additional systems; pertinent past, family and/or social history directly related to the patient's problems.
- Comprehensive -- chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family and social history.

The comprehensive history obtained as part of the preventive medicine evaluation and management service is not problem-oriented and does not involve a chief complaint of present illness. It does, however, include comprehensive system review and comprehensive or interval past, family and social history as well as a comprehensive assessment/history of pertinent risk factors.

v. DETERMINE THE EXTENT OF EXAMINATION PERFORMED: The levels of E/M services recognize four types of examination that are defined as follows:

- Problem Focused -- a limited examination of the affected body area or organ system.
- Expanded Problem Focused -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- Detailed -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- Comprehensive -- a general multi-system examination or a complete examination of a single organ system. **Note:** The comprehensive examination performed as part of the preventive medicine evaluation and management service is multi-system, but its extent is based on age and risk factors identified.

For the purpose of these definitions, the following body areas are recognized: head, including the face; neck; chest, including breasts and axilla; abdomen; genitalia, groin, buttocks; back and each extremity.

For the purposes of these definitions, the following organ systems are recognized: eyes; ears, nose, mouth and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; skin; neurologic; psychiatric; hematologic/lymphatic/immunologic.

vi. DETERMINE THE COMPLEXITY OF MEDICAL DECISION MAKING: Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and, high complexity. To qualify for a given type of decision making, two of the three elements in the table following must be met or exceeded:

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	Straight Forward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision making.

vii. SELECT THE APPROPRIATE LEVEL OF E/M SERVICES BASED ON THE FOLLOWING:

a. For the following categories/subcategories, **ALL OF THE KEY COMPONENTS** (ie, history, examination, and medical decision making), must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; hospital observation services; initial hospital care; office consultations; initial consultations, other than office; confirmatory consultations; emergency department services; comprehensive nursing facility assessments; domiciliary care, new patient; and home, new patient.

b. For the following categories/subcategories, **TWO OF THE THREE KEY COMPONENTS** (ie, history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; follow-up consultations, other than office; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

c. In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time**

is considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in locum parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.

NOTE: CLINICAL EXAMPLES: Clinical examples of the codes for E/M services are provided to assist practitioners in understanding the meaning of the descriptors and selecting the correct code.

The same problem, when seen by physicians in different specialties, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptor rather than the examples.

5. **SPECIALIST FEES:** A specialist shall be paid a specialist's fee if the services provided are within the field of his specialty, and only if he is registered with the New York State Department of Health in a specialty recognized by that Department. Specialists rendering primary care services as defined in Rule 1, may bill primary care office visit codes as appropriate.

6. **FAMILY PLANNING CARE:** In accordance with approval received by the State Director of the Budget, effective July 1, 1973 in the Medicaid Program, all family planning services are to be reported on claims using appropriate MMIS code numbers listed in this fee schedule in combination with modifier '-FP'.

   This reporting procedure will assure to New York State the higher level of federal reimbursement which is available when family planning services are provided to Medicaid patients (90% instead of 50% for other medical care). It will also provide the means to document conformity with mandated federal requirements on provision of family planning services.

7. **BY REPORT:** A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Additional items which may be included are: complexity of symptoms, final diagnosis, pertinent physical findings (such as size, locations, and number of lesion(s), if appropriate), diagnostic and therapeutic procedures (including major supplementary surgical procedures, if appropriate), concurrent problems, and follow-up care.

   When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service, the time, the skill and the equipment necessary, is to be furnished. Appropriate documentation (eg, operative report, procedure description, and/or itemized invoices) should accompany all claims submitted.

   Itemized invoices must document acquisition cost, the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations.

8. **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.

9. **MATERIALS SUPPLIED BY PHYSICIAN:** Supplies and materials provided by the physician, eg, sterile trays/drugs, **over and above** those usually included with the procedure(s), office visit or other services rendered may be listed separately. List drugs, trays, supplies and materials provided. Identify as 99070 or specific supply code.

   Reimbursement for supplies and materials (including drugs, vaccines and immune globulins) furnished by practitioners to their patients is based on the acquisition cost to the practitioner. For all items furnished in this fashion it is expected that the practitioner will maintain auditable records of the actual itemized invoice cost represented on the invoice. New York State Medicaid does not intend to pay more than the acquisition cost, 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 item provided.

10 **EVALUATION AND MANAGEMENT SERVICES (outpatient or inpatient):** Evaluation and management fees do not apply to preoperative consultations or follow-up visits as designated in accordance with the surgical fees listed in the SURGERY section of the State Medical Fee Schedule.

   For additional information on the appropriate circumstances governing the billing of the hospital visit procedure codes see **PHYSICIAN SERVICES PROVIDED IN HOSPITALS.**

11 **CRITICAL CARE:** Represents extraordinary care by the attending physician in personal attendance in the care of a medical emergency, both directing and personally administering specific corrective measures after initial examination had determined the nature of the ailment. See codes 99291, 99292. **NOTE: Report Required for 99292.**

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

13. **FEES:** Listed fees are the maximum reimbursable Medicaid fees**.**

MMIS MODIFIERS: MEDICINE SECTION

-24 Unrelated Evaluation and Management Service by the Same Practitioner During a Postoperative Period: The practitioner may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier -24 to the appropriate level of E/M service. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Practitioner on the Day of a Procedure: (Effective 10/1/92) The practitioner may need to indicate that on the day a procedure or service identified by an MMIS code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance maybe reported by adding the modifier -25 to the appropriate level of E/M service. **NOTE**: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-26 Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier -26 to the usual procedure number. (Reimbursement will not exceed 40% of the maximum State Medical Fee Schedule amount.)

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

-79 Unrelated Procedure or Service bv 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 using the modifier -79 to the usual procedure number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-AJ Clinical Social Worker: To report services of a Certified Social Worker (CSW) under the direct supervision of an employing psychiatrist, modifier –AJ should be added to the appropriate procedure code listed below. (Reimbursement will not exceed the indicated amount.) 90804 ($13.50), 90806 ($27.00), 90846 ($7.20), 90847 ($7.20), 90849 ($7.20), 90853 ($7.20), 90857 ($7.20).

-EP Child/Teen Health Program (EPSDT Program): Service provided as part of the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program or Child/Teen Health Program will be identified by adding the modifier -EP to the usual procedure number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-FP Service Provided as Part of Family Planning Program: All Family Planning Services will be identified by adding the modifier -FP to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical 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 State Medical Fee Schedule amount. One claim line should be billed.) **(Use modifier –50 when both sides done at same 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 State Medical Fee Schedule amount. One claim line should be billed.) **(Use modifier –50 when both sides done at same session.)**

-SL State Supplied Vaccine: (Used to identify administration of vaccine supplied by the Vaccine for Children's Program (VFC) for children under 19 years of age.) When administering vaccine supplied by the state (VFC program), you **must** append modifier –SL State Supplied Vaccine to the procedure code number representing the vaccine administered. Omission of this modifier on claims for recipients under 19 years of age will cause your claim to deny. (Reimbursement will not exceed $17.85, the administration fee for the VFC program.)

-99 Multiple Modifiers: Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier -99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

EVALUATION AND MANAGEMENT SERVICES

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

OFFICE OR OTHER OUTPATIENT SERVICES

The following codes are used to report evaluation and management services provided in the **practitioners office or in an outpatient or other ambulatory facility**. A patient is considered an outpatient until inpatient admission to a health care facility occurs. When claiming for Evaluation and Management procedure codes 99201-99205 and 99211-99215 Office or Other Outpatient Services, report the place of service code that represents the location where the service was rendered in claim form field 24B Place of Service. **The maximum reimbursable amount for these codes is dependent on the Place of Service reported.**

For Evaluation and Management services rendered in the practitioners private office, report place of service "11". The Maximum Fee for Office Evaluation and Management services is $30.00. For services rendered in a Hospital Outpatient setting report place of service "22". For the Maximum Fee for codes 99201-99205 and 99211-99215 in a Hospital Outpatient setting see pages 62 - 109.

For services provided by practitioners in the Emergency Department, see 99281-99285. **For services provided to hospital inpatients, see Hospital Services 99221-99239**.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care or comprehensive nursing facility assessments.

For observation care, see 99217-99220.

For observation or inpatient care services (including admission and discharge services), see 99234-99236.

NEW PATIENT

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination, and straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor. Practitioners typically spend 10 minutes face-to-face with the patient and/or family.

For example:

Office or other outpatient visit with a 65-year-old male for reassurance about an isolated seborrheic keratosis on the upper back.

continued

Office visit with a 10-year-old male with severe rash and itching for the past 24 hours, positive history for contact with poison oak 48 hours prior to the visit.

Office visit with an out-of-town visitor who needs a prescription refilled because she forgot her hay fever medication.

Office visit to advise for or against the removal of wisdom teeth, 18-year-old male referred by an orthodontist.

Visit with 9-month-old female with diaper rash.

Initial office visit with 5-year-old female to remove sutures from simple wound, placed by another physician.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requiresthese three key components: an expanded problem focused history, an expanded problem focused examination, and straightforward medical decision making.

Usually, the presenting problem(s) are of low to moderate severity. Practitioners typically spend 20 minutes face-to-face with the patient and/or family.

For example:

Initial office visit, 16-year-old male with severe cystic acne, new patient.

Initial evaluation and management of recurrent urinary infection in female.

Initial office evaluation for gradual hearing loss, 58-year-old male, history and physical examination, with interpretation of complete audiogram, air bone, etc.

Initial office visit with 10-year-old girl with history of chronic otitis media and a draining ear.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Practitioners typically spend 30 minutes face-to-face with the patient and/or family.

For example:

Office visit for initial evaluation of a 48-year-old man with recurrent low back pain radiating to the leg.

Initial office evaluation of 49-year-old male with nasal obstruction. Detailed exam with topical anesthesia.

Initial office evaluation for diagnosis and management of painless gross hematuria in new patient, without cystoscopy.

Initial office visit for evaluation of 13-year-old female with progressive scoliosis.

Initial office visit with couple for counseling concerning voluntary vasectomy for sterility. Spent 30 minutes discussing procedure, risks and benefits, and answering questions.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 45 minutes face-to-face with the patient and/or family.

For example:

Office visit for initial evaluation of a 63-year-old male with chest pain on exertion.

Initial office visit of a 50-year-old female with progressive solid food dysphagia.

Initial office evaluation of a 70-year-old patient with recent onset of episodic confusion.

Initial office visit for 7-year-old female with juvenile diabetes mellitus, new to area, past history of hospitalization times three.

Initial office evaluation of 70-year-old female with polyarthralgia.

Initial office evaluation of 50-year-old male with an aortic aneurysm with respect to recommendation for surgery.

99205 Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 60 minutes face-to-face with the patient and/or family.

For example:

Initial office evaluation of a 65-year-old female with exertional chest pain, intermittent claudication, syncope and a murmur of aortic stenosis.

Initial office evaluation and management of patient with systemic vasculitis and compromised circulation to the limbs.

Initial office visit for a 73-year-old male with an unexplained 20-pound weight loss.

Initial office visit for a 24-year-old homosexual male who has a fever, a cough, and shortness of breath.

Initial office evaluation, patient with systemic lupus erythematous, fever, seizures and profound thrombocytopenia.

Initial outpatient evaluation of a 69-year-old male with severe chronic obstructive pulmonary disease, congestive heart failure, and hypertension.

ESTABLISHED PATIENT

The following codes are used to report the evaluation and management services provided to established patients who present for follow-up and/or periodic reevaluation of problems or for the evaluation and management of new problem(s) in established patients.

99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician.

Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

For example:

Office visit with 19-year-old male, established patient, for supervised urine drug screen.

Office visit with 31-year-old female, established patient, for return to work certificate.

Office visit with 12-year-old male, established patient, for cursory check of hematoma one day after venipuncture.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history, a problem focused examination, and/or straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor. Practitioners typically spend 10 minutes face-to-face with the patient and/or family.

For example:

Office visit, established patient, 6-year-old child with sore throat and headache.

Office visit, sore throat, fever and fatigue in 19-year-old college student.

Office evaluation for possible purulent bacterial conjunctivitis with 1-2 day history of redness and discharge, 16-year-old female patient.

Office visit with 33-year-old female, established patient, recently started on treatment for hemorrhodial complaints, for reevaluation.

Office visit with 65-year-old female, established patient, returns for 3-week follow-up for resolving severe ankle sprain.

Office visit with 36-year-old male, established patient, for follow-up on effectiveness of medical management of oral candidiasis.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history, an expanded problem focused examination, and/or medical decision making of low complexity.

Usually, the presenting problem(s) are of low to moderate severity. Practitioners typically spend 15 minutes face-to-face with the patient and/or family.

For example:

Follow-up visit with 55-year-old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen.

Follow-up office visit for an established patient with stable cirrhosis of the liver.

Office visit with 31-year-old male, established patient, who is 3 years post total colectomy for chronic ulcerative colitis, presents for increased irritation at his stoma.

Routine, follow-up office evaluation at a three-month interval for a 77-year-old female with nodular small cleaved-cell lymphoma.

Follow-up visit for a 70-year-old diabetic hypertensive patient with recent change in insulin requirement.

Quarterly follow-up office visit for a 45-year-old male, with stable chronic asthma, on steroid and bronchodilator therapy.

Office visit with 80-year-old female established patient, for follow-up osteoporosis, status post compression fractures.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination, and/or medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 25 minutes face-to-face with the patient and/or family.

For example:

Office visit for a 68-year-old male with stable angina, two months post myocardial infarction, who is not tolerating one of his medications.

Office evaluation of 28-year-old patient with regional enteritis, diarrhea and low grade fever, established patient.

Weekly office visit for 5FU therapy for an ambulatory established patient with metastatic colon cancer and increasing shortness of breath.

Office visit with 50-year-old female, established patient, diabetic, blood sugar controlled by diet. She now complains of frequency of urination and weight loss, blood sugar of 320 and negative ketones on dipstick.

Follow-up office visit for a 60-year-old male whose post-traumatic seizures have disappeared on medication, and who now raises the question of stopping the medication.

Follow-up office visit for a 45-year-old patient with rheumatoid arthritis on gold, methotrexate, or immuno-suppressive therapy.

Office evaluation on new onset RLQ pain in a 32-year-old woman, established patient.

Office visit with 63-year-old female, established patient, with familial polyposis, after a previous colectomy and sphincter sparing procedure, now with tenesmus, mucus, and increased stool frequency.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history, a comprehensive examination, and/or medical decision making of high complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 40 minutes face-to-face with the patient and/or family.

For example:

Office visit with 30-year-old male, established patient for 3 month history of fatigue, weight loss, intermittent fever, and presenting with diffuse adenopathy and splenomegaly.

Office evaluation and discussion of treatment options for a 68-year-old male with biopsy-proven rectal carcinoma.

Office visit for restaging of an established patient with new lymphadenopathy one year post therapy for lymphoma.

Follow-up office visit for a 65-year-old male with a fever of recent onset while on outpatient antibiotic therapy for endocarditis.

Office visit for evaluation of recent onset syncopal attacks in a 70-year-old woman, established patient.

Follow-up office visit for a 75-year-old patient with ALS (amyotrophic lateral sclerosis), who is no longer able to swallow.

Follow-up visit, 40-year-old mother of 3, with acute rheumatoid arthritis, anatomical Stage 3, ARA function Class 3 rheumatoid arthritis, and deteriorating function.

HOSPITAL OBSERVATION SERVICES

The following codes are used to report evaluation and management services provided to patients designated/admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital. If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc.), these codes are to be utilized if the patient is placed in such an area.
Typical times have not yet been established for this category of services.

OBSERVATION CARE DISCHARGE SERVICES

Observation care discharge of a patient from "observation status" includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. For observation or inpatient hospital care including the admission and discharge of the patient on the same date, see codes 99234-99236 as appropriate.

99217 Observation care discharge day management (This code is to be utilized by the practitioner to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status". To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services (99234-99236))

INITIAL OBSERVATION CARE - NEW OR ESTABLISHED PATIENT

The following codes are used to report the encounter(s) by the supervising practitioner with the patient when designated as "observation status." This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic reassessments. For observation encounters by other physicians, see Inpatient Consultation codes (99251-99255).

To report services provided to a patient who is admitted to the hospital after receiving hospital observation care services on the same date, see the notes for initial hospital inpatient care. For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported with the appropriate initial hospital care codes (99221-99223). For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate. Do not report observation discharge (99217) in conjunction with the hospital admission.

When "observation status" is initiated in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office, nursing facility) all evaluation and management services provided by the supervising physician in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service reported by the supervising physician should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting. Evaluation and Management services on the same date provided in sites that are related to initiating "observation status" should NOT be reported separately.

These codes may not be utilized for post-operative recovery if the procedure is considered a part of the surgical "package". These codes apply to all Evaluation and Management services that are provided on the same date of initiating "observation status."

99218 Initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history, a detailed or comprehensive examination and medical decision making that is straightforward or of low complexity.

Usually the problem(s) requiring admission to "observation status" are of low severity.

99219 Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity.

Usually, the problem(s) requiring admission to "observation status" are of moderate severity.

99220 Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Usually, the problem(s) requiring admission to "observation status" are of high severity.

HOSPITAL INPATIENT SERVICES

The following codes are used to report evaluation and management services provided to HOSPITAL **INPATIENTS**. For Hospital Observation Services, see 99218-99220. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate. For services rendered in a hospital outpatient setting, see procedure codes 99201-99215 Office or Other Outpatient Services.

INITIAL HOSPITAL CARE - NEW OR ESTABLISHED PATIENT

The following codes are used to report the first hospital inpatient encounter with the patient by the admitting practitioner. For initial inpatient encounters by practitioners other than the admitting practitioner, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate.

99221 Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making that is straightforward or of low complexity.

Usually, the problem(s) requiring admission are of low severity. Practitioners typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

For example:

Hospital admission, examination, and initiation of treatment program for a 67-year-old male with an uncomplicated pneumonia who requires IV antibiotic therapy.

Hospital admission for a 12-year-old with a laceration of the upper eyelid involving the lid margin and superior canaliculus, admitted prior to surgery for IV antibiotic therapy.

Hospital admission for an 18-month-old child with 10 percent dehydration.

Hospital admission for a 32-year-old female with severe flank pain, hematuria and presumed diagnosis of ureteral calculus as determined by ED (Emergency Department) physician.

99222 Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity.

Usually, the problem(s) requiring admission are of moderate severity. Practitioners typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

For example:

Hospital admission, young adult patient, failed previous therapy and now presents in acute asthmatic attack.

Hospital admission for a 50-year-old with left lower quadrant abdominal pain and increased temperature, but without septic picture.

Hospital admission of a 62-year-old smoker, established patient, with bronchitis in acute respiratory distress.

Hospital admission, examination, and initiation of treatment program for a 66-year-old chronic hemodialysis patient with fever and a new pulmonary infiltrate.

Hospital admission, examination, and initiation of a treatment program for a 65-year-old female with new onset of right-sided paralysis and aphasia.

Hospital admission for a 3-year-old with high temperature, limp and painful hip motion of 18 hours duration.

99223 Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Usually, the problem(s) requiring admission are of high severity. Practitioners typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

For example:

Hospital admission, examination, and initiation of a treatment program for a previously unknown 58-year-old male who presents with acute chest pain.

Hospital admission for a 78-year-old female with left lower lobe pneumonia and a history of coronary artery disease, congestive heart failure, osteoarthritis and gout.

Hospital admission, examination, and initiation of induction chemotherapy for a 42-year-old patient with newly diagnosed acute myelogenous leukemia.

Hospital admission, examination, and initiation of treatment program for a 65-year-old immuno-suppressed male with confusion, a fever, and a headache.

Hospital admission following a motor vehicle accident for a 24-year-old male with fracture dislocation of C5-6; neurologically intact.

Hospital admission for a 9-year-old with vomiting, dehydration, fever, tachypnea and an admitting diagnosis of diabetic ketoacidosis.

SUBSEQUENT HOSPITAL CARE

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status, (i.e., changes in history, physical condition and response to management) since the last assessment by the practitioner.

99231 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history, a problem focused examination, and/or medical decision making that is straightforward or of low complexity.

Usually, the patient is stable, recovering or improving. Practitioners typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

For example:

Follow-up hospital visit for a 50-year-old male with uncomplicated myocardial infraction who is clinically stable and without chest pain.

Follow-up hospital visit for now stable 33-year-old male, status post lower gastrointestinal bleeding.

Follow-up hospital visit for a stable 72-year-old lung cancer patient undergoing a five day course of infusion chemotherapy.

Follow-up visit on third day of hospitalization for a 60-year-old female recovering from an uncomplicated pneumonia.

Follow-up hospital visit, two days post admission for a 65-year-old male with a CVA (cerebral vascular accident) and left hemiparesis, who is clinically stable.

Follow-up hospital visit for a 3-year-old patient in traction for a congenital dislocation of the hip.

99232 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history, an expanded problem focused examination, and/or medical decision making of moderate complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Practitioners typically spend 25 minutes at the bedside and on the patient's hospital floor or unit

For example:

Follow-up hospital visit for a 54-year-old patient, post MI (myocardial infraction), who is out of the CCU (coronary care unit) but is now having frequent premature ventricular contractions on telemetry.

Follow-up hospital visit for 81-year-old male with abdominal distention, nausea, and vomiting.

Follow-up hospital visit for a patient with neutropenia, a fever responding to antibiotics and continued slow gastrointestinal bleeding on platelet support.

Follow-up hospital care for a 62-year-old female with congestive heart failure, who remains dyspneic, and febrile.

Follow-up hospital visit for a 50-year-old male admitted two days ago for sub-acute renal allograft rejection.

Follow-up hospital visit for a 73-year-old female with recently diagnosed lung cancer, who complains of unsteady gait.

Follow-up hospital visit for a 35-year-old drug addict, not responding to initial antibiotic therapy for pyelonephritis.

99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history, a detailed examination, and/or medical decision making of high complexity.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Practitioners typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

For example:

Follow-up hospital visit for a 60-year-old female, 4 days post uncomplicated inferior myocardial infarction who has developed severe chest pain, dyspnea, diaphoressis and nausea.

Subsequent hospital visit for a 65-year-old female post-op resection of abdominal aortic aneurysm, with suspected ischemic bowel.

Follow-up hospital visit for a patient with AML (acute myelogenous leukemia), fever, elevated white count and uric acid, undergoing induction chemotherapy.

Follow-up hospital visit for a 60-year old female with persistent leukocytosis and a fever seven days after a sigmoid colon resection for carcinoma

Follow-up hospital visit for a 38-year-old quadriplegic male with acute autonomic hyperreflexia, who is not responsive to initial care.

Follow-up hospital visit for a chronic renal failure patient on dialysis, who develops chest pain, shortness of breath and new onset of pericardial friction rub.

OBSERVATION OR INPATIENT CARE SERVICES (INCLUDING ADMISSION AND DISCHARGE SERVICES)

The following codes are used to report observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service. When a patient is admitted to the hospital from observation status on the same date, the physician should report only the initial hospital care code. The initial hospital care code reported by the admitting physician should include the services related to the observation status services he/she provided on the same date of inpatient admission.

When "observation status" is initiated in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office, nursing facility) all evaluation and management services provided by the supervising physician in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting when provided by the same practitioner.

For patients admitted to observation or inpatient care and discharged on a different date, see codes 99218-99220 and 99217, or 99221-99223 and 99238-99239.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problems requiring admission are of low severity.

99234 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity.

Usually the presenting problem(s) requiring admission are of low severity.

99235 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.

Usually the presenting problem(s) requiring admission are of moderate severity.

99236 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity.

Usually the presenting problem(s) requiring admission are of high severity.

HOSPITAL DISCHARGE SERVICES

The hospital discharge day management codes are to be used to report the total duration of time spent by a practitioner for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the practitioner on that date is not continuous, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate.

99238 Hospital discharge day management; 30 minutes or less
99239 more than 30 minutes

(These codes are to be utilized by the practitioner to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient status. To report services to a patient who is admitted as an inpatient, and discharged on the same date, see codes 99234-99236 for observation or inpatient hospital care including the admission and discharge of the patient on the same date. To report concurrent care services provided by a practitioner(s) other than the attending practitioner, use subsequent hospital care codes (99231-99233) on the day of discharge.)

(For Observation Care Discharge, use 99217)

(For discharge services provided to newborns admitted and discharged on the same date, see 99435)

(For Nursing Facility Care Discharge, see 99315, 99316)

(For observation or inpatient hospital care including the admission and discharge of the patient on the same date, see 99234-99236)

CONSULTATIONS (BY SPECIALISTS)

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

The request for a consultation from the attending physician or other appropriate source and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

A "consultation" initiated by a patient and/or family is not reported using the consultation codes, but may be reported using the codes for visits, as appropriate.

Any specifically identifiable procedure (i.e., identified with a specific procedure code) performed on or subsequent to the date of the initial consultation should be reported separately.

If subsequent to the completion of a consultation, the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the consultation codes should not be used. In the hospital setting, the consulting physician should use the appropriate initial hospital care code for the initial encounter and subsequent hospital care codes (not follow-up consultation codes). In the office setting, the appropriate established patient code should be used.

There are two subcategories of consultations: office and initial inpatient consultation (other than office), See each subcategory for specific reporting instructions.

OFFICE OR OTHER OUTPATIENT CONSULTATION - NEW OR ESTABLISHED PATIENT

The following codes are used to report consultations provided in the **physician's office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, custodial care, or emergency department (see consultation definition, above).** When reporting procedure codes 99241-99245 with a place of service **office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule amount**.** Follow-up visits in the consultant's office or other outpatient facility that are initiated by the physician consultant are reported using office visit codes for established patients (99211-99215). If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used again.

Follow-up visits in the consultant's office that are initiated by the physician consultant are reported using office visit codes for established patients (99211-99215). If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician or other appropriate source and documented in the medical record, the office consultation codes may be used again.

99241 Office or other outpatient consultation for a new or established patient, which requires these three key components: a problem focused history, a problem focused examination, and straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

For example:

Office consultation with 25-year-old postpartum female with severe symptomatic hemorrhoids.

Office consultation with 58-year-old male, referred for follow-up creatinine level and evaluation of obstructive uropathy, relieved two months ago.

99242 Office or other outpatient consultation for a new or established patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and straightforward medical decision making.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

For example:

Office consultation for management of systolic hypertension in a 70-year-old male scheduled for elective prostate resection.

Office consultation with 66-year-old female with wrist and hand pain, and finger numbness, secondary to suspected carpal tunnel syndrome.

Office consultation with 27-year-old female, with old amputation, for evaluation of existing above knee prosthesis.

99243 Office or other outpatient consultation for a new or established patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

For example:

Initial office consultation for a 65-year-old female with persistent bronchitis.

Initial office consultation for a 65-year-old man with chronic low-back pain radiating to the leg.

99244 Office or other outpatient consultation for a new or established patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

For example*:*

Office consultation with 38-year-old female, with inflammatory bowel disease, who now presents with right lower quadrant pain and suspected intra-abdominal abscess.

Initial office consultation for discussion of treatment options for a 40-year-old female with a two-centimeter adenocarcinoma of the breast.

Initial office consultation with 72-year-old male with esophageal carcinoma, symptoms of dysphagia and reflux.

99245 Office or other outpatient consultation for a new or established patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

For example:

Office consultation for a 23-year-old female with State II A Hodgkin's disease with positive supraclavicular and mediastinal nodes.

INITIAL INPATIENT CONSULTATIONS - NEW OR ESTABLISHED PATIENT

The following codes are used to report physician consultations provided to hospital inpatients, residents of nursing facility, or patients in a partial hospital setting. Only one initial consultation should be reported by a consultant per admission.

99251 Initial inpatient consultation for a new or established patient, which requires these three key components: a problem focused history, a problem focused examination, and straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

For example:

Initial hospital consultation for a 30-year-old female complaining of vaginal itching, post orthopaedic surgery.

99252 Initial inpatient consultation for a new or established patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and straightforward medical decision making.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

For example:
Hospital consultation for possible drug eruption in 50-year-old male.
Preoperative hospital consultation for evaluation of hypertension in a 60-year-old male who will undergo a cholecystectomy. Patient had a normal annual check-up in your office four months ago.

Initial hospital consultation for recommendation of antibiotic prophylaxis for a patient with a synthetic heart valve who will undergo urologic surgery.

99253 Initial inpatient consultation for a new or established patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.

For example:

Initial hospital consultation for a 57-year-old male, post lower endoscopy, for evaluation of abdominal pain and fever.

Hospital consultation for diagnosis/management of fever following abdominal surgery.

Initial hospital consultation for rehabilitation of a 73-year-old female one week after surgical management of a hip fracture.

Initial hospital consultation for a 35-year-old female with a fever and pulmonary infiltrate following cesarean section.

99254 Initial inpatient consultation for a new or established patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.

For example:

Evaluation of 63-year-old in the ICU with diabetes and chronic renal failure who develops acute respiratory distress syndrome 36 hours after a mitral valve replacement.

Emergency hospital consultation for possible bowel obstruction in a 72-year-old patient.

Initial hospital consultation for a 66-year-old female with enlarged supraclavicular lymph nodes, found on biopsy to be malignant.

Initial hospital consultation for evaluation of a 71-year-old male with hyponatremia (serum sodium 114) who was admitted to the hospital with pneumonia.

Initial hospital consultation for a 43-year-old female for evaluation of sudden painful visual loss, optic neuritis and episodic paresthesia.

Consultation in hospital for 35-year-old female with fever, swollen joints, and rash of one week duration.

99255 Initial inpatient consultation for a new or established patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.

For example:

Initial hospital consultation in the ICU for a 70-year-old male who experienced a cardiac arrest during surgery and was resuscitated.

Initial consultation in the ICU for a 51-year-old patient who is on a ventilator and has a fever two weeks after a renal transplantation.

Initial hospital consultation for a patient with severe pancreatitis complicated by respiratory insufficiency, acute renal failure and abscess formation.

Initial evaluation and formulation of plan for management of multiple trauma patient with complex pelvic fracture, 35-year-old male.

Initial hospital consultation for a 70-year-old cirrhotic male admitted with ascites, jaundice, encephalopathy, and massive hematemesis.

Initial hospital consultation for a 50-year-old male with a history of previous myocardial infarction, now with acute pulmonary edema and hypotension.

EMERGENCY DEPARTMENT SERVICES - NEW OR ESTABLISHED PATIENT

The following codes are used to report evaluation and management services provided in the emergency department. No distinction is made between new and established patients in the emergency department.

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

For critical care services provided in the Emergency Department, see critical care notes and 99291-99292.

For evaluation and management services provided to a patient in an observation area of a hospital, see 99217-99220.

For observation or inpatient care services (including admission and discharge services), see 99234-99236.

99281 Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history, a problem focused examination, and straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor.

For example:

Emergency department visit for a patient for removal of sutures from a well-healed, uncomplicated laceration.

Emergency department visit for a patient for tetanus toxoid immunization.

Emergency department visit for a patient with several uncomplicated insect bites.

99282 Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and medical decision making of low complexity.

Usually, the presenting problem(s) are of low to moderate severity.

For example:

Emergency department visit for a 20-year-old student who presents with a painful sunburn with blister formation on the back.

Emergency department visit for a patient with a minor traumatic injury of an extremity with localized pain, swelling, and bruising.

Emergency department visit for a child presenting with impetigo localized to the face.

Emergency department visit for an otherwise healthy patient whose chief complaint is a red, swollen cystic lesion on his/her back.

Emergency department visit for a young adult patient with infected sclera and purulent discharge from both eyes without pain, visual disturbance or history of foreign body in either eye.

Emergency department visit for a patient presenting with a rash on both legs after exposure to poison ivy.

99283 Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate severity.

For example:

Emergency department visit for a sexually active female complaining of vaginal discharge who is afebrile and denies experiencing abdominal or back pain.

Emergency department visit for a patient with an inversion ankle injury, who is unable to bear weight on the injured foot and ankle.

Emergency department visit for a healthy, young adult patient who sustained a blunt head injury with local swelling and bruising **without** subsequent confusion, loss of consciousness or memory deficit.

Emergency department visit for a well-appearing 8-year-old child who has a fever, diarrhea and abdominal cramps, is tolerating oral fluids and is not vomiting.

Emergency department visit for a patient who has a complaint of acute pain associated with a suspected foreign body in the painful eye.

99284 Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of moderate complexity.

Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the practitioner but do not pose an immediate significant threat to life or physiologic function.

For example:

Emergency department visit for a 4-year-old child who fell off a bike sustaining a head injury with brief loss of consciousness.

Emergency department visit for a patient with flank pain and hematuria.

Emergency department visit for an elderly female who has fallen and is now complaining of pain in her right hip and is unable to walk.

Emergency department visit for a female presenting with lower abdominal pain and a vaginal discharge.

99285 Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: a comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

For example:

Emergency department visit for a patient with a complicated overdose requiring aggressive management to prevent side effects from the ingested material.

Emergency department visit for a patient exhibiting active, upper gastrointestinal bleeding.

Emergency department visit for a patient with an acute onset of chest pain compatible with symptoms of cardiac ischemia and/or pulmonary embolus.

Emergency department visit for a patient with a new onset of a cerebral vascular accident.

Emergency department visit for a patient with a new onset of rapid heart rate requiring IV drugs.

Emergency department visit for a previously healthy young adult patient who is injured in an automobile accident and is brought to the emergency department immobilized and has symptoms compatible with intra-abdominal injuries or multiple extremity injuries.

Emergency department visit for a patient who presents with a sudden onset of "the worst headache of her life," and complains of a stiff neck nausea, and inability to concentrate.

Emergency department visit for acute febrile illness in an adult, associated with shortness of breath and an altered level of alertness.

PEDIATRIC CRITICAL CARE PATIENT TRANSPORT

The following codes 99289 and 99290 are used to report the physical attendance and direct **face-to-face** care by a physician during the interfacility transport of a critically ill or critically injured pediatric patient. For the purpose of reporting codes 99289 and 99290, face-to-face care begins when the physician assumes primary responsibility for the pediatric patient at the referring hospital/facility, and ends when the receiving hospital/facility accepts responsibility for the pediatric patient's care. Only the time the physician spends in direct **face-to-face** contact with the patient during the transport should be reported. Pediatric patient transport services involving less than 30 minutes of face-to-face physician care should not be reported using codes 99289, 99290. Procedure(s) or service(s) performed by other members of the transporting team may not be reported by the supervising physician.

The following services are included when performed during the pediatric patient transport by the physician providing critical care and may not be reported separately: routine monitoring evaluations (eg, heart rate, respiratory rate, blood pressure, and pulse oximetry), the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry, blood gases and information data stored in computers (eg, ECG's, blood pressures, hematologic data), gastric intubation pressures, hematologic data), gastric intubation (43752), temporary transcutaneous pacing (92953), ventilatory management and vascular access procedures (36000, 36400, 36405, 36406, 36540, 36600). Any services performed which are not listed above should be reported separately.

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critcial illness or injury acutely impairs one or more vital organ systems such as that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.

Providing medical care to a crtically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements.

The direction of emergency care to transporting staff by a physician located in a hospital or other facility by two-way communication is not considered direct face-to-face care and should not be reported with codes 99289, 99290. Physician direction of emergency care through outside voice communication to transporting staff personnel is not reimbursable as a separate procedure.

The emergency department service codes (99281-99285), initial hospital care codes (99221-99223), hourly critical care codes (99291, 99292), or initial neonatal intensive care code (99295) are only reported after the patient has been admitted to the emergency department, the inpatient floor or the critical care unit of the receiving facility.

Code 99289 is used to report the first 30-74 minutes of direct face-to-face time with the transport pediatric patient and should be reported only once on a given date. Code 99290 is used to report each additional 30 minutes provided on a given date. Face-to-face services less than 30 minutes should not be reported with these codes. **(Report Required)**

99289 Critical care services delivered by a physician, face-to-face, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or less; **Report Required** first 30-74 minutes of hands on care during transport

99290 each additional 30 minutes **(Report Required)**
(List separately in addition to code for primary service)
(Use 99290 in conjunction with 99289)

(Critical care of less than 30 minutes total duration should be reported with the appropriate E/M code)

CRITICAL CARE SERVICES

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vitalorgan system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

Inpatient critical care services provided to infants 29 days up through 24 months of age are reported with pediatric critical care codes 99293 and 99294. The pediatric critical care codes are reported as long as the infant/young child qualifies for critical care services during the hospital stay through 24 months of age. Inpatient critical care services provided to neonates (28 days of age or less) are reported with the neonatal critical care codes 99295 and 99296. The neonatal critical care codes are reported as long as the neonate qualifies for critical care services during the hospital stay through the 28th postnatal day. The reporting of the pediatric and neonatal critical care services is not based on the time or the type of unit (eg, pediatric or neonatal critical care unit) and it is not dependent upon the type of provider delivering the care. To report critical care services provided in the outpatient setting (eg, emergency department or office), for neonates and pediatric patients up through 24 months of age, see the hourly Critical Care codes 99291, 99292. If the same physician provides critical care services for a neonatal or pediatric patient in both the outpatient and inpatient settings on the same day, report only the appropriate Neonatal or Pediatric Critical Care code (99293-99296) for all critical care services provided on that day. For additional instructions on reporting these services , see the Neonatal and Pediatric Critical Care section and codes 99293-99296.

Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.

Critical care and other E/M services may be provided to the same patient on the same date by the same physician.

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (eg, ECGs, blood pressures, hematologic data (99090)); gastric intubation (43752, 91105); temporary transcutaneous pacing (92953), ventilatory management (94656, 94657, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36540, 36600). Any services performed which are not listed above should be reported seperately.

Codes 99291, 99292 should be reported for the physician's attendance during the transport of critically ill or critically injured patients over 24 months of aget o or from a facility or hospital. For physician transport services of critically ill or critically injured pediatric patients 24 months of age or less see 99289, 99290.

The critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

Time spent with the individual patient should be recorded in the patient's record. The time that can be reported as critical care is the time spent engaged in work directly related to the individual patient's care, whether that time was spent at the immediate bedside or elsewhere on the floor or unit. For example, time spent on the unit or at the nursing station on the floor reviewing test results or imaging studies, discussing the critically ill patient;s care with other medical staff or documenting critical care services in the medical record would be reported as critical care, even though it does not occur at the bedside. Also, when the patient is unable or clinically incompetent to participate in discussions, time spent on the floor or unit with family members or surrogate decision makers obtaining a medical history, reviewing the patient's condition or prognosis, or discussing treatment or limitation(s) of treatment may be reported as critical care, provided that the conversation bears directly on the management of the patient.

Time spent in activites that occur outside of the unit or off the floor (eg, telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient. Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit (eg, participation in administrative meetings or telephone calls to discuss other patients). Time spent performing seperately reportable procedures or services should not be included in the time reported as critical care time.

Code 99291 is used to report the first 30-74 minutes of critical care on a given date. It should be used only once per date even if the time spent by the physician is not continuous on that date. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code.

99291 Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician**;** first hour
99292 each additional 30 minutes
(List separately in addition to code for primary service)

INPATIENT NEONATAL AND PEDIATRIC CRITICAL CARE SERVICES

The following codes (99293-99296) are used to report services provided by a neonatologist or pediatric critical care specialist directing the inpatient care of a critically ill neonate/infant. The same definitions for critical care services apply for the adult, child, and neonate.

The initial day neonatal critical care code (99295) can be used in addition to code 99440 as appropriate, when the physician is present for the delivery and newborn resuscitation is required. Other procedures performed as a necessary part of the resuscitation (eg, endotracheal intubation) are also reported separately.

Codes 99295, 99296 are used to report services provided by a **neonatologist** directing the inpatient care of a critically ill neonate through the first 28 days of life. They represent care starting with the date of admission (99295) and subsequent day(s) (99296) and may be reported only once per day, per patient. Once the neonate is no longer considered to be critically ill, the Continuing Intensive Care Services codes for those with present body weight of less than 2500 grams (99298, 99299) or the codes for Subsequent Hospital Care (99231-99233) for those with present body weight over 2500 grams should be utilized.

Codes 99293, 99294 are used to report services provided by a **neonatologist or pediatric critical care specialist** directing the inpatient care of a critically ill infant or young child from 29 days of postnatal age through 24 months of age. They represent care starting with the date of admission (99293) and subsequent day(s) (99294) and may be reported by a single pediatric critcial care specialist only once per day, per patient in a given setting. The critically ill or critically injured child older than two years when admitted to an intensive care unit would be reported with hourly critical care service codes (99291, 99292). Once an infant is no longer considered to be critically ill but continues to require intensive care, the Continuing Intensive Care Services codes (99298, 99299) should be used to report services for infants with present body weight of less than 2500 grams. When the present body weight of those infants exceeds 2500 grams, the Subsequent Hospital Care (99231-99233) codes should be utilized.

Care rendered under 99293-99296 includes management, monitoring, and treatment of the patient including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematologic maintenance, parent/family counseling, case management services, and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

The pediatric and neonatal critical care codes include those procedures listed above for the hourly critical care codes (99291, 99292). In addition, the following procedures are also included in the bundled (global) pediatric and neonatal critical care services codes (99293-99296): umbilical venous (36510) and umbilical arterial (36660) catheters, central (36488, 36490) or peripheral vessel catheterization (36000), other arterial catheters (36140, 36620), oral or nasogastric tube placement (43752), endotracheal intubation (31500), lumbar puncture (62270), suprapubic bladder aspiration (51000), bladder catheterization, initiation and management of mechanical ventilation or continuous positive airway pressure (CPAP)

surfactant administration, intravascular fluid administration (90760, 90768), transfusion of blood components (36430, 36440), vascular punctures (36420, 36600), invasive or non-invasive electronic monitoring of vital signs, bedside pulmonary function testing (94375) and/or monitoring or interpretation of blood gases or oxygen saturation and/or prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (33960, 33961). Any services performed which are not listed above should be reported separately.

For additional instructions, see descriptions listed for 99293-99296.

INPATIENT PEDIATRIC CRITICAL CARE

99293 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age

99294 Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age

INPATIENT NEONATAL CRITICAL CARE

99295 Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less

This code is reserved for the date of admission for neonates who are critically ill. Critically ill neonates require cardiac and/or respiratory support (including ventilator or nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up **neonatologist** reevaluations**,** and constant observation by the health care team under direct **neonatologist** supervision. Immediate preoperative evaluation and stabilization of neonates with life threatening surgical or cardiac conditions are included under this code. Neonates with life threatening surgical or cardiac conditions are included under this code.

Care for neonates who require an intensive care setting but who are not critically ill is reported using the initial hospital care codes (99221-99223).

99296 Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less

A critically ill neonate will require cardiac and/or respiratory support (including ventilator or nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up **neonatologist** reevaluations throughout a 24 hour period, and constant observation by the health care team under direct **neonatalogist** supervision.

CONTINUING INTENSIVE CARE SERIVCES

Codes 99298, 99299 and 99300 are used to report services subsequent to the day of admission provided by a **neonatologist or pediatric critical care specialist** directing the continuing intensive care of the low birth weight (LBW, 1500-2500 grams present body weight) infant, very low birth weight (VLBW, less than 1500 grams present body weight) infant, or normal weight (2501-5000 grams present body weight) newborn who do not meet the definition of critically ill but continue to require intensive observation, frequent interventions and other intensive services. Codes 99298-99300 represent subsequent day(s) of care and may be reported only once per calendar day, per patient and are global codes with the same services bundled as outlined under codes 99293-99296.

For additional instructions, see descriptions listed for 99298-99300.

99298 Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams) (Neonatologist or Pediatric Critical Care Specialist only)

Infants with present body weight less than 1500 grams who are not critically ill but continue to require intensive cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring and constant observation by the health care team under the direct **neonatologist or pediatric critical care specialist** supervision. **Neonatologist or pediatric critical care specialist** reevaluations throughout a 24 hour period.

99299 Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams) (Neonatologist or Pediatric Critical Care Specialist only)

Infants with present body wieght of 1500-2500 grams who are not critically ill but continue to require intensive cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen montioring and constant observation by the health care team under direct neonatalogist or pediatric critical care specialist supervision.

99300 Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)

Infants with present body wieght of 2501-5000 grams who are no longer critically ill but continue to require intensive cardiac and respiratory monitoring, continuous and /or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen montioring, and constant observation by the health care team under direct neonatalogist or pediatric critical care specialist supervision.

NURSING FACILITY SERVICES

The following codes are used to report evaluation and management services to patients in Nursing Facilities (formerly called Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs) or Long Term Care Facilities (LTCFs)).

INITIAL NURSING FACILITY CARE - NEW OR ESTABLISHED PATIENT

More than one comprehensive assessment may be necessary during an inpatient confinement.

99304 Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity.

Usually the problem(s) requiring admission are of low severity.

99305 Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.

Usually the problem(s) requiring admission are of moderate severity.

99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity.

Usually, the problem(s) requiring admission are of high severity.

SUBSEQUENT NURSING FACILITY CARE - NEW OR ESTABLISHED PATIENT

The following codes are used to report the services provided to residents of nursing facilities who do not require a comprehensive assessment, and/or who have not had a major, permanent change of status.

All levels include reviewing the medical record, noting changes in the resident's status since the last visit, and reviewing and signing orders.

99307 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a problem focused interval history, a problem focused examination, and/or medical decision making that is straightforward.

Usually, the patient is stable, recovering or improving.

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three components: an expanded problem focused interval history, an expanded problem focued examination, and/or medical decision making of low complexity

Usually, the patient is responding inadequately to therapy or has developed a minor complication

99309 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a detailed interval history, a detailed examination, and/or medical decision making of moderate complexity.

Usually, the patient has developed a significant complication or a significant new problem.

99310 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a comprehensive interval history, a comprehensive examination, and/or medical decision making of high complexity.

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.

NURSING FACILITY DISCHARGE SERVICES

The nursing facility discharge day management codes are to be used to report the total duration of time spent by a practitioner for the final nursing facility discharge of patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent by the physician on that date is not continuous. Instructions are given for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.

99315 Nursing facility discharge day management; 30 minutes or less
99316 more than 30 minutes

DOMICILIARY, REST HOME (e.g., BOARDING HOME), OR CUSTODIAL CARE SERVICES

The following codes are used to report evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. The facility's services do not include a medical component. Typical times have not yet been established for this category of services.

NEW PATIENT

99324 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination, and medical decision making that is straightforward.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.

99325 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.

99326 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.

99327 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity.

Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

99328 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.

ESTABLISHED PATIENT

99334 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history, a problem focused examination, and/or medical decision making that is straightforward.

Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver.

99335 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history, an expanded problem focused examination, and/or medical decision making of low complexity.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.

99336 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history, a detailed examination, and/or medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.

99337 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history, a comprehensive examination, and medical decision making of moderate to high complexity.

Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

HOME SERVICES

The following codes are used to report evaluation and management services provided in a private residence.

NEW PATIENT

99341 Home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination, and medical decision making that is straightforward.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99342 Home visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99343 Home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

99344 Home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination; and medical decision making of moderate complexity.

Usually the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

99345 Home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination and medical decision making of high complexity.

Usually the patient is unstable or has developed a significant new problem requiring immediate Physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.

ESTABLISHED PATIENT

99347 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; straightforward medical decision making.

Usually the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99348 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity.

Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99349 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity.

Usually the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

99350 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of moderate to high complexity.

Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Codes 99354-99357 are used when a physician provides prolonged service involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting. This service is reported in addition to other physician service, including evaluation and management services at any level. Appropriate codes should be selected for supplies provided or procedures performed in the care of the patient during this period. **(Report Required)**

PROLONGED SERVICES

PROLONGED PHYSICIAN SERVICE WITH DIRECT (FACE-TO-FACE) PATIENT CONTACT

Codes 99354-99357 are used when a physician provides prolonged service involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting. This service is reported in addition to other physician service, including evaluation and management services at any level. Appropriate codes should be selected for supplies provided or procedures performed in the care of the patient during this period. **(Report Required)**

Codes 99354-99357 are used to report the total duration of face-to-face time spent by a physician on a given date providing prolonged service, even if the time spent by the physician on that date is not continuous.

Code 99354 or 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service. Either code also may be used to report a total duration of prolonged service of 30-60 minutes on a given date. Either code should be used only once per date, even if the time spent by the physician is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes.

Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour, depending on the place of service. Either code may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

99354 Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting)**(Report Required);** first hour
(Use 99354 in conjunction with codes 99201-99215, 99241-99245, 99304-99350)

99355 each additional 30 minutes
(Use 99355 in conjunction with code 99354)

99356 Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (e.g., maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient) **(Report Required);** first hour
(Use 99356 in conjunction with codes 99221-99233, 99251-99255)

99357 each additional 30 minutes
(Use 99357 in conjunction with code 99356)

PREVENTIVE MEDICINE SERVICES

The following codes are used to report well visit services provided to patients ages 0-20 years old, in the pratitioner's private office setting only.

NEW PATIENT

99381 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; **infant (age under 1 year)**

99382 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; **early childhood (age 1 through 4 years)**

99383 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; **late childhood (age 5 through 11 years)**

99384 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; adolescent **(age 12 through 17 years)**

99385 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; **(18-20 years)**

ESTABLISHED PATIENT

99391 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; infant **(age under 1 year)**

99392 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; early childhood **(age 1 through 4 years)**

99393 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)

99394 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; adolescent **(age 12 through 17 years)**

99395 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; **(18-20 years)**

NEWBORN CARE

The following codes are used to report the services provided to newborns in several different settings. For newborn hospital discharge services provided on a date subsequent to the admission date of the newborn, use 99238. For discharge services provided to newborns admitted and discharged on the same date, see 99435.

99431 History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records. (This code should also be used for birthing room deliveries.)

99433 Subsequent hospital care, for the evaluation and management of a normal newborn, per day.

99435 History and examination of the normal newborn infant, including the preparation of medical records (this code should only be used for newborns assessed and discharged from the hospital or birthing room on the same date)

99440 Newborn resuscitation: provision of a positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output.

OFFICE SERVICES – ALL PHYSICIANS

See General Information and Rules for definitions and examples of Evaluation and Management services.

For Physician Specialty Code(s), see Appendix A.

PRIMARY CARE OFFICE SERVICES - See General Information and Rules #1

The following reimbursement amounts are for services rendered in the practitioner's private office. For services rendered in a hospital outpatient setting see the appropriate list of reimbursement amounts by Physician specialty for "Hospital Outpatient Services".

NEW PATIENT (**Problem Visit**)		ESTABLISHED PATIENT (**Problem Visit**)	
Procedure Code	Maximum Fee	Procedure Code	Maximum Fee
99201	30.00	99211	30.00
99202	30.00	99212	30.00
99203	30.00	99213	30.00
99204	30.00	99214	30.00
99205	30.00	99215	30.00

NEW PATIENT (**Well Visit, Ages 0-20**)		ESTABLISHED PATIENT (**Well Visit, Ages 0-20**)	
99381	30.00	99391	30.00
99382	30.00	99392	30.00
99383	30.00	99393	30.00
99384	30.00	99394	30.00
99385	30.00	99395	30.00

VISITS BY NON-SPECIALISTS: General Practice

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see above, Office Services – All Physicians.

NEW PATIENT		ESTABLISHED PATIENT	
Procedure Code	Maximum Fee	Procedure Code	Maximum Fee
99201	6.50	99211	5.00
99202	6.50	99212	5.00
99203	6.50	99213	5.00
99204	6.50	99214	5.00
99205	6.50	99215	5.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICE		INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT	
Procedure Code	Maximum Fee	Procedure Code	Maximum Fee
99217	5.00	99218	6.50
		99219	6.50
		99220	6.50

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT		SUBSEQUENT HOSPITAL CARE	
Procedure Code	Maximum Fee	Procedure Code	Maximum Fee
99221	6.50	99231	5.00
99222	6.50	99232	5.00
99223	6.50	99233	5.00

OBSERVATION OR INPATIENT CARE SERVICES

(Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	6.50
99235	6.50
99236	6.50

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	5.00
99239	5.00

EMERGENCY DEPARTMENT SERVICES

NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99281	6.50
99282	6.50
99283	6.50
99284	6.50
99285	6.50

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	8.00
99305	8.00
99306	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.00
99308	7.00
99309	7.00
99310	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	8.00
99316	8.00

DOMICILLARY, REST HOME (eg, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	8.00
99325	8.00
99326	8.00
99327	8.00
99328	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	7.00
99335	7.00
99336	7.00
99337	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	7.00
99342	7.00
99343	8.00
99344	8.00
99345	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	7.00
99348	7.00
99349	8.00
99350	8.00

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee
99431	6.50
99433	5.00
99435	6.50

VISITS BY SPECIALISTS: Allergy and Immunology (**010**), Colon and Rectal Surgery (**030**), Dermatology (**040**), Otolaryngology (**120**), Pediatric Surgery (**153**), Physical Medicine and Rehabilitation (**160**), Plastic Surgery (**170**), General Surgery (**210**), Thoracic Surgery (**220**), or Urology (**230**)

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see Office Services–All Physicians.

NEW PATIENT

Procedure Code	Maximum Fee
99201	10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99211	6.00
99212	6.00
99213	6.00
99214	6.00
99215	6.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee
99217	6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99218	10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99221	10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee
99231	6.00
99232	6.00
99233	6.00

OBSERVATION OR INPATIENT CARE SERVICES

(Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99241-99245 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee
99241	20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee
99251	20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee
99281	10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	8.00
99305	8.00
99306	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.00
99308	7.00
99309	7.00
99310	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	8.00
99316	8.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	8.00
99325	8.00
99326	8.00
99327	8.00
99328	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	7.00
99335	7.00
99336	7.00
99337	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	10.00
99342	10.00
99343	12.50
99344	12.50
99345	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	10.00
99348	10.00
99349	12.50
99350	12.50

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee
99431	6.50
99433	5.00
99435	6.50

VISITS BY SPECIALISTS: Anesthesiology **(020)**

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see Office Services-All Physicians.

NEW PATIENT

Procedure Code	Maximum Fee
99201	10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99211	6.00
99212	6.00
99213	6.00
99214	6.00
99215	6.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee
99217	6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99218	10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99221	10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee
99231	6.00
99232	6.00
99233	6.00

OBSERVATION OR INPATIENT CARE SERVICES

(Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99241-99245 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee
99241	20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee
99251	20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

EMERGENCY DEPARTMENT SERVICES

NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99281	10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	8.00
99305	8.00
99306	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.00
99308	7.00
99309	7.00
99310	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	8.00
99316	8.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	8.00
99325	8.00
99326	8.00
99327	8.00
99328	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	7.00
99335	7.00
99336	7.00
99337	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	7.00
99342	7.00
99343	8.00
99344	8.00
99345	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	7.00
99348	7.00
99349	8.00
99350	8.00

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee
99431	6.50
99433	5.00
99435	6.50
99440	25.00

VISITS BY SPECIALISTS: Family Practice **(050)**, General Preventive Medicine **(182)**, Occupational Medicine **(183)**, Public Health **(184)**, Aerospace Medicine **(185)**

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see Office Services-All Physicians.

NEW PATIENT

Procedure Code	Maximum Fee
99201	12.50
99202	12.50
99203	12.50
99204	12.50
99205	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99211	7.50
99212	7.50
99213	7.50
99214	7.50
99215	7.50

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee
99217	7.50

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99218	12.50
99219	12.50
99220	12.50

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99221	12.50
99222	12.50
99223	12.50

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee
99231	7.50
99232	7.50
99233	7.50

OBSERVATION OR INPATIENT CARE SERVICES

(Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	12.50
99235	12.50
99236	12.50

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	7.50
99239	7.50

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99241-99245 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee
99241	20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee
99251	20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99281	12.50
99282	12.50
99283	12.50
99284	12.50
99285	12.50

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	9.00
99305	9.00
99306	9.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.50
99308	7.50
99309	7.50
99310	7.50

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	9.00
99316	9.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	10.00
99325	10.00
99326	12.50
99327	12.50
99328	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	10.00
99335	10.00
99336	12.50
99337	12.50

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	10.00
99342	10.00
99343	12.50
99344	12.50
99345	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	10.00
99348	10.00
99349	12.50
99350	12.50

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee
99431	12.50
99433	7.50
99435	12.50

VISITS BY SPECIALISTS: Internal Medicine **(060),** Cardiovascular Disease **(062),** Endocrinology and Metabolism **(063),** Gastroenterology **(064),** Hematology **(065),** Infectious Disease **(066),** Nephrology **(067),** Pulmonary Disease **(068),** Rheumatology **(069)** or Medical Oncology **(241)**

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see Office Services-All Physicians.

NEW PATIENT

Procedure Code	Maximum Fee
99201	15.00
99202	20.00
99203	20.00
99204	25.00
99205	25.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99211	7.50
99212	7.50
99213	7.50
99214	7.50
99215	7.50

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee
99217	7.50

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99218	15.00
99219	20.00
99220	25.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99221	15.00
99222	20.00
99223	25.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee
99231	7.50
99232	7.50
99233	7.50

OBSERVATION OR INPATIENT CARE SERVICES

(Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	15.00
99235	20.00
99236	25.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	7.50
99239	7.50

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99241-99245 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee
99241	20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee
99251	20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99281	15.00
99282	20.00
99283	20.00
99284	25.00
99285	25.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	9.00
99305	9.00
99306	9.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.50
99308	7.50
99309	7.50
99310	7.50

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	9.00
99316	9.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	10.00
99325	10.00
99326	20.00
99327	20.00
99328	25.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	15.00
99335	15.00
99336	20.00
99337	25.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	15.00
99342	15.00
99343	20.00
99344	25.00
99345	25.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	15.00
99348	15.00
99349	20.00
99350	25.00

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee
99431	6.50
99433	5.00
99435	6.50

VISITS BY SPECIALISTS: Neurological Surgery **(070),** Child Neurology **(193),** Neurology **(194)**

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see Office Services-All Pyhsicians.

NEW PATIENT

Procedure Code	Maximum Fee
99201	15.00
99202	20.00
99203	20.00
99204	25.00
99205	25.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99211	7.50
99212	7.50
99213	7.50
99214	7.50
99215	7.50

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee
99217	7.50

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99218	15.00
99219	20.00
99220	25.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99221	15.00
99222	20.00
99223	25.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee
99231	7.50
99232	7.50
99233	7.50

OBSERVATION OR INPATIENT CARE SERVICES

(Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	15.00
99235	20.00
99236	25.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	7.50
99239	7.50

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99241-99245 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee
99241	20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee
99251	20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99281	15.00
99282	20.00
99283	20.00
99284	25.00
99285	25.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	8.00
99305	8.00
99306	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.00
99308	7.00
99309	7.00
99310	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	8.00
99316	8.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	8.00
99325	8.00
99326	8.00
99327	8.00
99328	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	7.00
99335	7.00
99336	7.00
99337	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	15.00
99342	15.00
99343	15.00
99344	25.00
99345	25.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	15.00
99348	15.00
99349	15.00
99350	20.00

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee
99431	6.50
99433	5.00
99435	6.50

VISITS BY SPECIALISTS: Obstetrics and Gynecology **(089),** Maternal and Fetal Medicine **(092),** Reproductive Endocrinology **(093),** Gynecologic Oncology **(242)**

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see Office Services-All Physicians.

NEW PATIENT

Procedure Code	Maximum Fee
99201	10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99211	6.00
99212	6.00
99213	6.00
99214	6.00
99215	6.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee
99217	6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99218	10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99221	10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee
99231	6.00
99232	6.00
99233	6.00

OBSERVATION OR INPATIENT CARE SERVICES
(Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99241-99245 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee
99241	20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee
99251	20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99281	10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	8.00
99305	8.00
99306	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.00
99308	7.00
99309	7.00
99310	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	8.00
99316	8.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	8.00
99325	8.00
99326	8.00
99327	8.00
99328	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	7.00
99335	7.00
99336	7.00
99337	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	10.00
99342	10.00
99343	12.50
99344	12.50
99345	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	10.00
99348	10.00
99349	12.50
99350	12.50

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee
99431	6.50
99433	5.00
99435	6.50

VISITS BY SPECIALISTS: Ophthalmology **(100)**

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see Office Services-All Physicians.

NEW PATIENT

Procedure Code	Maximum Fee
99201	10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99211	6.00
99212	6.00
99213	6.00
99214	6.00
99215	6.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee
99217	6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99218	10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99221	10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee
99231	6.00
99232	6.00
99233	6.00

OBSERVATION OR INPATIENT CARE SERVICES
(Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99241-99245 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee
99241	20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee
99251	20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99281	10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	8.00
99305	8.00
99306	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.00
99308	7.00
99309	7.00
99310	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	8.00
99316	8.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	8.00
99325	8.00
99326	8.00
99327	8.00
99328	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	7.00
99335	7.00
99336	7.00
99337	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	10.00
99342	10.00
99343	12.50
99344	12.50
99345	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	10.00
99348	10.00
99349	12.50
99350	12.50

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee
99431	6.50
99433	5.00
99435	6.50

VISITS BY SPECIALISTS: Pediatrics **(150),** Pediatric Cardiology **(151),** Pediatric Hematology-Oncology **(152),** Pediatric Nephrology **(154),** Neonatal-Perinatal Medicine **(155),** Pediatric Endocrinology **(156),** Pediatric Pulmonology **(157**), Pediatric Critical Care **(161),** Pediatric Gastroenterology **(163)**

For purposes of reimbursement under the New York State Medicaid program, Pediatricians are considered to be providing specialty services when treating patients under age 21. Services rendered to patients 21 years of age or older should be billed using the appropriate General Practitioner or Primary Care Services procedure codes.

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see Office Services-All Physicians.

NEW PATIENT

Procedure Code	Maximum Fee
99201	10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99211	6.00
99212	6.00
99213	6.00
99214	6.00
99215	6.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee
99217	6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99218	10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99221	10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee
99231	6.00
99232	6.00
99233	6.00

OBSERVATION OR INPATIENT CARE SERVICES
(Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99241-99245 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee
99241	20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee
99251	20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99281	10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

PEDIATRIC CRITICAL CARE PATIENT TRANSPORT

Procedure Code	Maximum Fee
99289	25.00
99290	12.50

PEDIATRIC CRITICAL CARE

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

PEDIATRIC CRITICAL CARE NEONATAL-PERINATAL MEDICINE **(155)** AND PEDIATRIC CRITICAL CARE **(161)** SPECIALTIES ONLY

Procedure Code	Maximum Fee
99293	206.00
99294	114.00

NEONATAL CRITICAL CARE

NEONATAL-PERINATAL MEDICINE **(155)** ONLY

Procedure Code	Maximum Fee
99295	233.00
99296	115.00

CONTINUING INTENSIVE CARE SERVICES

NEONATAL-PERINATAL MEDICINE **(155)** AND PEDIATRIC CRITICAL CARE **(161)** SPECIALTIES ONLY

Procedure Code	Maximum Fee
99298	57.00
99299	54.00
99300	50.00

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	8.00
99305	8.00
99306	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.00
99308	7.00
99309	7.00
99310	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	8.00
99316	8.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	8.00
99325	8.00
99326	8.00
99327	8.00
99328	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	7.00
99335	7.00
99336	7.00
99337	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	9.00
99342	9.00
99343	10.00
99344	10.00
99345	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	9.00
99348	9.00
99349	10.00
99350	10.00

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50
99440	25.00

NEWBORN CARE

Procedure Code	Maximum Fee
99431	10.00
99433	6.00
99435	10.00

VISITS BY SPECIALISTS: Child Psychiatry **(191),** Psychiatry **(192),** Psychiatry and Neurology **(195)**

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see Office Services-All Physicians.

NEW PATIENT

Procedure Code	Maximum Fee
99201	10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99211	6.00
99212	6.00
99213	6.00
99214	6.00
99215	6.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee
99217	6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99218	10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99221	10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee
99231	6.00
99232	6.00
99233	6.00

OBSERVATION OR INPATIENT CARE SERVICES (Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99241-99245 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee
99241	20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee
99251	20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99281	10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	9.00
99305	9.00
99306	9.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.50
99308	7.50
99309	7.50
99310	7.50

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	9.00
99316	9.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	10.00
99325	10.00
99326	10.00
99327	10.00
99328	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	6.00
99335	6.00
99336	6.00
99337	6.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	10.00
99342	10.00
99343	10.00
99344	10.00
99345	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	6.00
99348	6.00
99349	6.00
99350	6.00

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee
99431	6.50
99433	5.00
99435	6.50

VISITS BY SPECIALISTS: Nuclear Medicine **(080**), Radiology **(200),** Diagnostic Radiology **(201),** Diagnostic Radiology with Special Competence in Nuclear Radiology (**202),** Therapeutic Radiology **(205)**

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see Office Services-All Physicians.

NEW PATIENT

Procedure Code	Maximum Fee
99201	10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99211	6.00
99212	6.00
99213	6.00
99214	6.00
99215	6.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee
99217	6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99218	10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99221	10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee
99231	6.00
99232	6.00
99233	6.00

OBSERVATION OR INPATIENT CARE SERVICES (Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99241-99245 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee
99241	20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee
99251	20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99281	10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	8.00
99305	8.00
99306	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.00
99308	7.00
99309	7.00
99310	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	8.00
99316	8.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	8.00
99325	8.00
99326	8.00
99327	8.00
99328	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	7.00
99335	7.00
99336	7.00
99337	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	7.00
99342	7.00
99343	8.00
99344	8.00
99345	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	7.00
99348	7.00
99349	8.00
99350	8.00

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee
99431	6.50
99433	5.00
99435	6.50

VISITS BY SPECIALISTS: Emergency Medicine **(250)**

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see Office Services-All Physicians.

NEW PATIENT

Procedure Code	Maximum Fee
99201	12.50
99202	12.50
99203	12.50
99204	12.50
99205	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99211	6.00
99212	6.00
99213	6.00
99214	6.00
99215	6.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee
99217	6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99218	12.50
99219	12.50
99220	12.50

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99221	12.50
99222	12.50
99223	12.50

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee
99231	6.00
99232	6.00
99233	6.00

OBSERVATION OR INPATIENT CARE SERVICES
(Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	12.50
99235	12.50
99236	12.50

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	6.00
99239	6.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99281	17.00
99282	17.00
99283	17.00
99284	17.00
99285	17.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	8.00
99305	8.00
99306	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.00
99308	7.00
99309	7.00
99310	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	8.00
99316	8.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	8.00
99325	8.00
99326	8.00
99327	8.00
99328	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	7.00
99335	7.00
99336	7.00
99337	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	7.00
99342	7.00
99343	8.00
99344	8.00
99345	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	7.00
99348	7.00
99349	8.00
99350	8.00

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee
99431	6.50
99433	5.00
99435	6.50

VISITS BY SPECIALISTS: Orthopedic Surgery **(110)**

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see Office Services-All Physicians.

NEW PATIENT

Procedure Code	Maximum Fee
99201	10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99211	6.00
99212	6.00
99213	6.00
99214	6.00
99215	6.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee
99217	6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99218	10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99221	10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee
99231	6.00
99232	6.00
99233	6.00

OBSERVATION OR INPATIENT CARE SERVICES
(Including Admission and Discharge Services)

Procedure Code	Maximum Fee
99234	10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee
99238	6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99241-99245 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee
99241	20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee
99251	20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99281	10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee
99291	25.00
99292	12.50

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99304	8.00
99305	8.00
99306	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99307	7.00
99308	7.00
99309	7.00
99310	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee
99315	8.00
99316	8.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99324	8.00
99325	8.00
99326	8.00
99327	8.00
99328	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99334	7.00
99335	7.00
99336	7.00
99337	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee
99341	9.00
99342	9.00
99343	9.00
99344	9.00
99345	9.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee
99347	9.00
99348	9.00
99349	9.00
99350	9.00

PROLONGED SERVICES

Prolonged Physician Service with direct (face-to-face) patient contact

Procedure Code	Maximum Fee
99354	25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee
99431	6.50
99433	5.00
99435	6.50

PREFERRED PHYSICIAN AND CHILDRENS PROGRAM (PPAC)(158)

OFFICE SERVICES

The following reimbursement amounts are for services rendered in the practitioner's private office. For services rendered in a hospital outpatient setting see the list of reimbursement amounts for "Hospital Outpatient Services".

NEW PATIENT (**Problem Visits**)

Procedure Code	Maximum Fee Co. Group A	Maximum Fee Co. Group B
99201	39.64	33.63
99202	39.64	33.63
99203	39.64	33.63
99204	39.64	33.63
99205	39.64	33.63

ESTABLISHED PATIENT (**Problem Visits**)

Procedure Code	Maximum Fee Co. Group A	Maximum Fee Co. Group B
99211	39.64	33.63
99212	39.64	33.63
99213	39.64	33.63
99214	39.64	33.63
99215	39.64	33.63

NEW PATIENT (**Well Visits**)

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99381	39.64	33.63
99382	39.64	33.63
99383	39.64	33.63
99384	39.64	33.63
99385	39.64	33.63

ESTABLISHED PATIENT (**Well Visits**)

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99391	39.64	33.63
99392	39.64	33.63
99393	39.64	33.63
99394	39.64	33.63
99395	39.64	33.63

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see above.

NEW PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99201	36.00	30.00
99202	36.00	30.00
99203	36.00	30.00
99204	36.00	30.00
99205	36.00	30.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99211	36.00	30.00
99212	36.00	30.00
99213	36.00	30.00
99214	36.00	30.00
99215	36.00	30.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99217	36.00	30.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99218	36.00	30.00
99219	36.00	30.00
99220	36.00	30.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99221	36.00	30.00
99222	36.00	30.00
99223	36.00	30.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99231	36.00	30.00
99232	36.00	30.00
99233	36.00	30.00

OBSERVATION OR INPATIENT CARE SERVICES
(Including Admission and Discharge Services)

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99234	36.00	30.00
99235	36.00	30.00
99236	36.00	30.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99238	36.00	30.00
99239	36.00	30.00

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE
NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99304	36.00	30.00
99305	36.00	30.00
99306	36.00	30.00

SUBSEQUENT NURSING FACILITY CARE
NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99307	36.00	30.00
99308	36.00	30.00
99309	36.00	30.00
99310	36.00	30.00

NURSING FACILITY DISCARGE SERVICES

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99315	36.00	30.00
99316	36.00	30.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99324	36.00	30.00
99325	36.00	30.00
99326	36.00	30.00
99327	36.00	30.00
99328	36.00	30.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99334	36.00	30.00
99335	36.00	30.00
99336	36.00	30.00
99337	36.00	30.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99341	36.00	30.00
99342	36.00	30.00
99343	36.00	30.00
99344	36.00	30.00
99345	36.00	30.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99347	36.00	30.00
99348	36.00	30.00
99349	36.00	30.00
99350	36.00	30.00

HIV ENHANCED FEES FOR PHYSICIAN PROGRAM (HIV-RFP)(249)

OFFICE SERVICES

The following reimbursement amounts are for services rendered in the practitioner's private office. For services rendered in a hospital outpatient setting see the list of reimbursement amounts for "Hospital Outpatient Services".

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99201	42.22	37.35
99202	42.22	37.35
99203	42.22	37.35
99204	42.22	37.35
99205	42.22	37.35
99211	42.22	37.35
99212	42.22	37.35
99213	42.22	37.35
99214	42.22	37.35
99215	42.22	37.35

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see page above.

NEW PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99201	36.00	30.00
99202	36.00	30.00
99203	36.00	30.00
99204	36.00	30.00
99205	36.00	30.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99211	36.00	30.00
99212	36.00	30.00
99213	36.00	30.00
99214	36.00	30.00
99215	36.00	30.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99217	36.00	30.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99218	36.00	30.00
99219	36.00	30.00
99220	36.00	30.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE
NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99221	36.00	30.00
99222	36.00	30.00
99223	36.00	30.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99231	36.00	30.00
99232	36.00	30.00
99233	36.00	30.00

OBSERVATION OR INPATIENT CARE SERVICES
(Including Admission and Discharge Services)

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99234	36.00	30.00
99235	36.00	30.00
99236	36.00	30.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99238	36.00	30.00
99239	36.00	30.00

EMERGENCY DEPARTMENT SERVICES

NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99281	36.00	30.00
99282	36.00	30.00
99283	36.00	30.00
99284	36.00	30.00
99285	36.00	30.00

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY CARE
NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99304	36.00	30.00
99305	36.00	30.00
99306	36.00	30.00

SUBSEQUENT NURSING FACILITY
CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99307	36.00	30.00
99308	36.00	30.00
99309	36.00	30.00
99310	36.00	30.00

NURSING FACILITY DISCARGE SERVICES

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99315	36.00	30.00
99316	36.00	30.00

DOMICILLARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99324	36.00	30.00
99325	36.00	30.00
99326	36.00	30.00
99327	36.00	30.00
99328	36.00	30.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99334	36.00	30.00
99335	36.00	30.00
99336	36.00	30.00
99337	36.00	30.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99341	36.00	30.00
99342	36.00	30.00
99343	36.00	30.00
99344	36.00	30.00
99345	36.00	30.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99347	36.00	30.00
99348	36.00	30.00
99349	36.00	30.00
99350	36.00	30.00

CODE	DESCRIPTION	FEE

LABORATORY SERVICES PERFORMED IN A PHYSICIAN'S OFFICE

Certain laboratory procedures specified below are eligible for direct physician reimbursement when performed in the office of the physician in the course of treatment of his own patients.

The physician must be registered with the federal Health Care Finance Administration (HCFA) to perform laboratory procedures as required by the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA '88).

Procedures other than those specified must be performed by a laboratory, holding a valid clinical laboratory permit in the commensurate laboratory, specialty issued by the New York State Department of Health or, where appropriate, the New York City Department of Health.

For detection of pregnancy, use code 81025.

Procedure code 85025 complete blood count (CBC), may not be billed with its component codes 85007, 85013, 85018, 85041 or 85048.

81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specificgravity, urobilinogen, any number of these constituents; non-automated, with microscopy	4.00
81002	Non-automated, without microscopy	2.00
81015	Urinalysis; microscopic only	2.00
81025	Urine pregnancy test, by visual color comparison methods	2.00
85007	Blood count; blood smear, microscopic examination with manual differential WBC count (includes RBC morphology and platelet estimation)	1.43
85013	spun microhematocrit	2.00
85018	hemoglobin (Hgb)	2.00
85025	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	3.17
85041	red blood cell (RBC) automated	3.17
85048	leukocyte (WBC), automated	3.17
85651	Sedimentation rate, erythrocyte; non-automated	2.00
85652	automated	2.00
87081	Culture, presumptive, pathogenic organisms, screening only (throat only)	5.20
87880	Infectious agent detection by immunoassay with direct optical observation; streptococcus, group A (throat only)	3.75

NOTE: Medicare reimburses for these services at 100 percent. No Medicare co-insurance payments may be billed for the above listed procedure codes.

CODE DESCRIPTION

DRUG ADMINISTRATION

IMMUNIZATIONS

If a significantly separately identifiable Evaluation and Management services (eg, office service, preventative medicine services) is performed, the appropriate E/M code should be reported in addition to the vaccine and toxoid codes.

Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, a minimal service may be listed in addition to the injection. Immunization procedures include reimbursement for the supply of materials **and administration**.

For dates of service on or after 7/1/03 when immunization materials are supplied by the Vaccine for Children Program (VFC), bill using the procedure code that represents the immunization(s) administered and **append modifier –SL State Supplied Vaccine** to receive the VFC administration fee. See Medicine Section Modifiers for further information.

NOTE: The maximum fees for immunization injection codes are adjusted periodically by the State to reflect the current acquisition cost of the antigen. For immunizations not supplied by the VFC Program insert acquisition cost per dose plus a two dollar ($2.00) administration fee in amount charged field on claim form. For codes listed **BR**, also attach itemized invoice to claim form.

(For allergy testing, allergy vaccines and venom proteins, see Allergy and Clinical Immunology Section)

To meet the reporting requirements of immunization registries, vaccine distribution programs, and reporting systems (eg, Vaccine Adverse Event Reporting System) the exact vaccine product administered needs to be reported with modifier -SL. Multiple codes for a particular vaccine are provided in CPT when the schedule (number of doses or timing) differs for two or more products of the same vaccine type (eg, hepatitus A, Hib) or the vaccine product is available in more than one chemical formulation, dosage, or route of administration.

Reimbursement for drugs (including vaccines and immune globulins) 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.

Separate codes are available for combination vaccines (eg, DTP-Hib, DtaP-Hib, HepB-Hib). It is inappropriate to code each component of a combination vaccine separately. If a specific vaccine code is not available, the Unlisted procedure code should be reported, until a new code becomes available.

CODE	DESCRIPTION	

IMMUNE GLOBULINS

Immune globulin products listed here include broad-spectrum and anti-infective immune globulins, antitoxins, and various isoantibodies.

90281	Immune Globulin (Ig), human, for intramuscular use (per 1 ml)	
90283	Immune Globulin (IgIV), human, for intravenous use (per 500 mg)	
90291	Cytomegalovirus Immune Globulin (CMV-IgIV), human, for intravenous use	BR
90371	Hepatitis B Immune Globulin (HBIg), human, for intramuscular use	
90375	Rabies Immune Globulin (RIg), human, for intramuscular and/or subcutaneous use (150 IU/ml)	
90376	Rabies Immune Globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use	BR
90379	Respiratory Syncytial Virus Immune Globulin (RVS-IgIV), human, for intravenous use (per 50 mg)	
90384	Rho(D) Immune Globulin (RhIg), human, full-dose, for intramuscular use	
90385	Rho(D) Immune Globulin (RhIg), human, mini-dose, for intramuscular use	
90386	Rho(D) Immune Globulin (RhIgIV), human, for intravenous use (per 1500 IU)	
90389	Tetanus Immune Globulin (TIg), human, for intramuscular use (up to 250 units)	
90393	Vaccinia Immune Globulin, human, for intramuscular use	BR
90396	Varicella-Zoster Immune Globulin, human, for intramuscular use (per 62.5 u/ml)	
90399	Unlisted Immune Globulin	BR

VACCINES/TOXOIDS

When billing for vaccine supplied by the Vaccine for Childrens Program, append modifier – **SL** to the appropriate procedure code to receive the VFC administration fee.

90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90636	Hepatitis A and Hepatitis B vaccine (Hep-A – Hep-B), adult dose for intramuscular use
90645	Hemophilus Influenza B vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90646	Hemophilus Influenza B vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647	Hemophilus Influenza B vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648	Hemophilus Influenza B vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 of age, for intramuscular use

CODE	DESCRIPTION
90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use
90665	Lyme Disease vaccine, adult dosage, for intramuscular use
90669	Pneumococcal Conjugate vaccine, polyvalent, for children under five years, for intramuscular use
90675	Rabies vaccine, for intramuscular use
90676	Rabies vaccine, for intradermal use
90690	Typhoid vaccine, live, oral
90691	Typhoid vaccine, VI capsular polysaccharide (ViCPs), for intramuscular use
90692	Typhoid vaccine, heat- and phenol-inactivated (H-P), for subcutaneous or intradermal use
90700	Diphtheria, Tetanus toxoids, and Acellular Pertussis vaccine (DTaP), for use in individuals younger than 7 years, for intramuscular use
90701	Diphtheria, Tetanus toxoids, and whole cell Pertussis vaccine (DTP), for intramuscular use
90702	Diphtheria and Tetanus toxoids (DT) adsorbed for use in individuals younger than seven years, for intramuscular use
90703	Tetanus toxoid adsorbed, for intramuscular use
90704	Mumps virus vaccine, live, for subcutaneous use
90705	Measles virus vaccine, live, for subcutaneous use
90706	Rubella virus vaccine, live, for subcutaneous use
90707	Measles, Mumps and Rubella virus vaccine (MMR), live, for subcutaneous use
90708	Measles and Rubella virus vaccine, live, for subcutaneous use
90710	Measles, Mumps, Rubella, and Varicella vaccine (MMRV), live, for subcutaneous use
90712	Poliovirus vaccine, (any type(s)) (OPV), live, for oral use
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
90714	Tetanus and Diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals 7 years or older, for intramuscular use
90715	Tetanus, Diphtheria toxoids and Acellular Pertussis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine, live, for subcutaneous use
90717	Yellow Fever vaccine, live, for subcutaneous use
90718	Tetanus and Diphtheria toxoids (Td) adsorbed for use in individuals 7 years or older, for intramuscular use
90720	Diphtheria, Tetanus toxoids, and whole cell Pertussis vaccine and Hemophilus Influenza B vaccine (DTP-Hib), for intramuscular use
90721	Diphtheria, Tetanus toxoids, and Acellular Pertussis vaccine and Hemophilus Influenza B vaccine (DtaP-Hib), for intramuscular use
90723	Diphtheria, Tetanus toxoids, Acellular Pertussis vaccine, Hepatitis B, and Poliovirus vaccine, inactivated (DtaP-Hep B-IPV), for intramuscular use

CODE	DESCRIPTION
90725	Cholera vaccine for injectable use
90732	Pneumococcal Polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal Polysaccharide vaccine (any group(s)), for subcutaneous use
90734	Meningococcal Conjugate vaccine, serogroups A, C, Y and W-135 (Tetravalent), for intramuscular use
90735	Japanese Encephalitis virus vaccine, for subcutaneous use
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744	Hepatitis B vaccine; pediatric/adolescent dosage, (3 dose schedule) for intramuscular use
90746	Hepatitis B vaccine; adult dose, for intramuscular use
90747	dialysis or immunosuppressed patient, dosage (4 dose schedule), for intramuscular use
90748	Hepatitis B and Hemophilus Influenza B (Hep B -HIB), for intramuscular use
90749	Unlisted vaccine/toxoid

HYDRATION, THERAPEUTIC, PROPHYLACTIC AND DIAGNOSTIC INJECTIONS AND INFUSIONS (EXCLUDES CHEMOTHERAPY)

Physician work related to hydration, injection, and infusion services predominantly involves affirmation of treatment plan and direct supervision of staff.

If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported using modifier 25 in addition to 90760-90779. For same day E/M service a different diagnosis is not required.

If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

a. Use of local anesthesia
b. IV start
c. Access to indwelling IV, subcutaneous catheter or port
d. Flush at conclusion of infusion
e. Standard tubing, syringes, and supplies

(For declotting a catheter or port, see 36550)

When multiple drugs are administered, report the service(s) and the specific materials or drugs for each.

When administering multiple infusions, injections or combinations, only one “initial’’ service code should be reported, unless protocol requires that two separate IV sites must be used. The “initial’’ code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported (eg, the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code).

When reporting codes for which infusion time is a factor, use the actual time over which the infusion is administered.

HYDRATION

Codes 90760-90761 are intended to report a hydration iv infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-1/2 normal saline+30mEq KCL/liter), but are not used to report infusion of drugs or other substances. Hydration IV infusions typically require direct physician supervision for purposes of consent, safety oversight, or intraservice supervision of staff. Typically such infusions require little special handling to prepare or dispose of, and staff that administer these do not typically require advanced practice training. After initial set-up, infusion typically entails little patient risk and thus little monitoring.

90760 Intravenous infusion, hydration; initial, up to one hour 35.00
(Do not report 90760 if performed as a concurrent infusion service)

90761 each additional hour, up to eight (8) hours 5.00
(List separately in addition to primary procedure)

(Use 90761 in conjunction with 90760)
(Report 90761 for hydration infusion intervals of greater than 30 minutes beyond 1 hour increments)
(Report 90761 to identify hydration if provided as a secondary or subsequent service after a different initial service [90760, 90765, 90774, 96409, 96413] is provided).

THERAPEUTIC, PROPHYLACTIC AND DIAGNOSTIC INJECTIONS AND INFUSIONS (EXCLUDES CHEMOTHERAPY)

A therapeutic, prophylactic or diagnosis IV infusion or injection (90765-90779) (other than hydration) is for the administration of substances/drugs. The fluid used to administer the drug(s) is incidental hydration and is not separately reportable. These services typically require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intra-service supervision of staff. Typically such infusions require special consideration to prepare, dose or dispose of, require practice training and competency for staff who administer the infusions, and require periodic patient assessment with vital sign monitoring during the infusion.

CODE	DESCRIPTION	

Intravenous or intra-arterial push is defined as: a) an injection in which the health care professional who administers the substance/drug is continuously present to administer the injection and observe the patient, or b) aninfusion of 15 minutes or less.

(Do not report 90765-90779 with codes for which IV push or infusion is an inherent part of the procedure (eg, administration of contrast material for a diagnostic imaging study))

(These codes are not to be used for intradermal, subcutaneous or intramuscular or routine IV drug injections. These codes may not be used in addition to prolinged service codes)

90765	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	35.00
90766	each additional hour, up to 8 hours (List separately in addition to primary procedure)	5.00
90767	additional sequential infusion, up to 1 hour (List separately in addition to primary procedure)	5.00
90768	concurrent infusion (List separately in addition to primary procedure)	5.00
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	BR

DRUGS ADMINISTERED OTHER THAN ORAL METHOD

THERAPEUTIC INJECTIONS

The following list of drugs can be injected either subcutaneous, intramuscular or intravenous. A listing of chemotherapy drugs can be found in the Chemotherapy Section.

NOTE: The maximum fees for these drugs are adjusted periodically by the State to reflect the estimated acquisition cost. Insert acquisition cost per dose in amount charged field on claim form. For codes listed BR, also attach itemized invoice to claim form.

Reimbursement for drugs (including vaccines and immune globulins) 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.

J0135	Adalimumab, 20 mg
J0150	Injection Adenosine, for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use unlisted code)
J0170	Adrenalin, Epinephrine, up to 1 ml ampule

CODE	DESCRIPTION
J0180	Agalsidase Beta, 1 mg
J0205	Alglucerase, per 10 units
J0207	Amifostine, 500 mg
J0210	Methyldopate HCL (Aldomet), up to 250 mg
J0215	Alefacept (Amevive), 0.5 mg
J0256	Alpha 1-Proteinase Inhibitor-Human, 10 mg
J0270	Alprostadil, per 1.25 mcg (administered under direct physician supervision, not for self-administration)
J0275	Alprostadil Urethral Suppository (administered under direct physician supervision, not for self-administration)
J0280	Aminophyllin, up to 250 mg
J0290	Ampicillin Sodium, 500 mg
J0295	Ampicillin Sodium/Sulbactam Sodium, per 1.5 gm
J0300	Amobarbital, up to 125 mg
J0360	Hydralazine HCL, up to 20 mg
J0380	Metaraminol Bitartrate, per 10 mg
J0390	Chloroquine Hydrochloride, up to 250 mg
J0456	Azithromycin, 500 mg
J0460	Atropine Sulfate, up to 0.3 mg
J0470	Dimercaprol, per 100 mg
J0475	Baclofen, 10 mg
J0500	Dicyclomine HCl, up to 20 mg
J0515	Benztropine Mesylate, per 1 mg
J0520	Bethanechol Chloride, Mytonachol or Urecholine, up to 5 mg
J0530	Penicillin G Benzathine and Penicillin G Procaine, up to 600,000 units
J0540	Penicillin G Benzathine and Penicillin G Procaine, up to 1,200,000 units
J0550	Penicillin G Benzathine and Penicillin G Procaine, up to 2,400,000 units
J0560	Penicillin G Benzathine, up to 600,000 units
J0570	Penicillin G Benzathine, up to 1,200,000 units
J0580	Penicillin G Benzathine, up to 2,400,000 units
J0585	Botulinum Toxin Type A, per unit
J0587	Botulinum toxin type B, per 100 units
J0600	Edetate Calcium Disodium (Calcium Disodium Versenate), up to 1000 mg
J0610	Calcium Gluconate, per 10 ml
J0620	Calcium Glycerophosphate and Calcium Lactate, per 10 ml
J0630	Calcitonin-Salmon (Calcimar), up to 400 units
J0636	Calcitrol, 0.1 mcg
J0640	Leucovorin Calcium, per 50 mg
J0690	Cefazolin Sodium, 500 mg
J0694	Cefoxitin Sodium, 1 gm
J0696	Ceftriaxone Sodium, per 250 mg
J0697	Sterile Cefuroxime Sodium, per 750 mg
J0698	Cefotaxime Sodium, per gm
J0702	Betamethasone Acetate and Betamethasone Sodium Phosphate, per 3 Mg (1 unit= 3 mg. of Betamethasone Acetate and 3 mg of Betamethasone Sodium Phosphate)
J0704	Betamethasone Sodium Phosphate, per 4 mg
J0710	Cephapirin Sodium (Cefadyl), up to 1 gm

CODE	DESCRIPTION
J0713	Ceftazidime, per 500 mg
J0715	Ceftizoxime Sodium, per 500 mg
J0720	Chloramphenicol Sodium Succinate (Chloromycetin Sodium Succinate), up to 1 gm
J0725	Chorionic Gonadotropin, per 1,000 USP units
J0740	Cidofovir, 375 mg
J0744	Ciprofloxacin for intravenous infusion, 200 mg
J0745	Codeine Phosphate, per 30 mg
J0760	Colchicine, per 1 mg
J0770	Colistimethate Sodium (Coly-Mycin M), up to 150 mg
J0780	Prochlorperazine (Compazine), up to 10 mg
J0795	Corticorelin Ovine Triflutate, 1 mcg
J0835	Cosyntropin, per 0.25 mg
J0881	Darbepoetin alfa, 1 mcg (**Non-ESRD** use)
J0885	Epoetin alfa, (**Non-ESRD** use), 1000 units
J0895	Deferoxamine Mesylate, 500 mg
J0900	Testosterone Enanthate and Estradiol Valerate, up to 1 cc
J0945	Brompheniramine Maleate, per 10 mg
J0970	Estradiol Valerate (Delestrogen), up to 40 mg
J1000	Depo-Estradiol Cypionate, up to 5 mg
J1020	Methylprednisolone Acetate (Depo-Medrol), 20 mg
J1030	Methylprednisolone Acetate (Depo-Medrol), 40 mg
J1040	Methylprednisolone Acetate (Depo-Medrol), 80 mg
J1051	Medroxyprogesterone Acetate (Depo-Provera Aq.), 50 mg
J1055	Medroxyprogesterone Acetate (Depo-Provera Ag.), for contraceptive use, 150 mg
J1056	Medroxyprogesterone Acetate/Estradiol Cypionate, 5 mg/25mg
J1060	Testosterone Cypionate and Estradiol Cypionate (Depo-Testadiol), up to 1 ml
J1070	Testosterone Cypionate (Depo-Testosterone Cypionate), up to 100 mg
J1080	Testosterone Cypionate (Depo-Testosterone Cypionate), 1 cc, 200 mg
J1094	Dexamethasone Acetate, 1 mg
J1100	Dexamethasone Sodium Phosphate, 1 mg
J1110	Dihydroergotamine Mesylate, per 1 mg
J1120	Acetazolamide Sodium, up to 500 mg
J1160	Digoxin, up to 0.5 mg
J1165	Phenytoin Sodium, per 50 mg
J1170	Hydromorphone, up to 4 mg
J1180	Dyphylline, up to 500 mg
J1190	Dexrazoxane Hydrochloride, per 250 mg
J1200	Diphenhydramine HCL, up to 50 mg
J1205	Chlorothiazide Sodium, per 500 mg
J1212	DMSO, Dimethyl Sulfoxide, 50%, 50 ml
J1230	Methadone HCL, up to 10 mg
J1240	Dimenhydrinate, up to 50 mg
J1260	Dolasetron Mesylate, 10 mg
J1320	Amitriptyline HCL (Elavil HCL), up to 20 mg
J1330	Ergonovine Maleate (Ergotrate Maleate), up to 0.2 mg
J1364	Erythromycin Lactobionate, per 500 mg
J1380	Estradiol Valerate, up to 10 mg
J1390	Estradiol Valerate, up to 20 mg

CODE	DESCRIPTION	
J1410	Estrogen Conjugated, per 25 mg	
J1435	Estrone, per 1 mg	
J1436	Etidronate Disodium, per 300 mg	
J1438	Etanercept, 25 mg (administered under direct physician supervision, not self administered)	
J1440	Filgrastim (G-CSF) (Neupogen), 300 mcg	
J1441	Filgrastim (G-CSF) (Neupogen), 480 mcg	
J1450	Fluconazole, 200 mg	
J1452	Fomivirsen Sodium, intraocular, 1.65 mg	
J1455	Foscarnet Sodium, per 1000 mg	
J1570	Ganciclovir Sodium, 500 mg	
J1580	Garamycin, Gentamicin, up to 80 mg	
J1590	Gatifloxacin, 10 mg	
J1595	Glatiramer Acetate, 20 mg	
J1600	Gold Sodium Thiomaleate, up to 50 mg	
J1610	Glucagon Hydrochloride, per 1 mg	
J1620	Gonadorelin Hydrochloride, per 100 mcg	
J1626	Granisetron Hydrochloride, 100 mcg	
J1630	Haloperidol (Haldol), up to 5 mg	
J1631	Haloperidol Decanoate (Haldol), per 50 mg	
J1642	Heparin Sodium, (heparin lock flush), per 10 units	
J1644	Heparin Sodium, per 1000 units	
J1645	Dalteparin Sodium, per 2500 IU	
J1652	Fondaparinux Sodium, 0.5 mg	
J1655	Tinzaparin Sodium, 1000 IU	
J1710	Hydrocortisone Sodium Phosphate (Hydrocortone Phosphate), up to 50 mg	
J1720	Hydrocortisone Sodium Succinate (Solu-Cortef), up to 100 mg	
J1730	Diazoxide (Hyperstat), up to 300 mg	
J1745	Infliximab (Remicade), 10 mg	
J1751	Iron Dextran 165, 50 mg	
J1752	Iron Dextran 267, 50 mg	
J1756	Iron Sucrose, 1 mg	
J1785	Imiglucerase, per unit (per vial)	BR
J1790	Droperidol, up to 5 mg	
J1800	Propranolol HCL (Inderal), up to 1 mg	
J1815	Insulin, per 5 units	
J1817	Insulin (i.e., insulin pump) per 50 units	
J1825	Interferon Beta-1a, 33 mcg (administered under direct physician supervision, not for self-administration)	
J1830	Interferon Beta-1b, 0.25 mg (administered under direct physician supervision, not for self-administration)	
J1840	Kanamycin Sulfate (Kantrex), up to 500 mg	
J1850	Kanamycin Sulfate (Kantrex Pediatric), up to 75 mg	
J1885	Ketorolac Tromethamine, per 15 mg	
J1890	Cephalothin Sodium (Keflin), up to 1 gm	
J1931	Laronidase, 0.1 mg	
J1940	Furosemide (Lasix), up to 20 mg	

CODE	DESCRIPTION
J1950	Leuprolide Acetate (for depot suspension), per 3.75 mg
J1955	Levocarnitine, per 1 gm
J1960	Levorphanol Tartrate (Levo-Dromoran), up to 2 mg
J1980	Hyoscyamine Sulfate (Levsin), up to 0.25 mg
J1990	Chlordiazepoxide HCL (Librium), up to 100 mg
J2001	Lidocaine HCL for intravenous infusion, 10 mg
J2010	Lincomycin HCL (Lincocin), up to 300 mg
J2060	Lorazepam, 2 mg
J2150	Mannitol, 25% in 50 ml
J2175	Meperidine Hydrochloride, per 100 mg
J2210	Methylergonovine Maleate (Methergine Maleate), up to 0.2 mg
J2260	Milrinone Lactate, per 5 mg
J2270	Morphine Sulfate, up to 10 mg
J2275	Morphine Sulfate (preservative-free sterile solution), per 10 mg
J2278	Ziconotide, 1 mcg
J2320	Nandrolone Decanoate, up to 50 mg
J2321	Nandrolone Decanoate, up to 100 mg
J2322	Nandrolone Decanoate, up to 200 mg
J2353	Octreotide, depot form for intramuscular injection, 1 mg
J2355	Oprelvekin, 5 mg
J2357	Omalizumab (Xolair), 5 mg
J2360	Orphenadrine Citrate (Norflex), up to 60 mg
J2370	Phenylephrine HCL (Neo-Synephrine), up to 1 ml
J2405	Odansetron Hydrochloride (Zofran), per 1 mg
J2410	Oxymorphone HCL (Numorphan), up to 1 mg
J2425	Palifermin, 50 mcg
J2430	Pamidronate Disodium, per 30 mg
J2440	Papaverine HCL, up to 60 mg
J2460	Oxytetracycline HCL, up to 50 mg
J2469	Palonosetron HCL, 25 mcg
J2503	Pegaptanib sodium, 0.3 mg
J2504	Pegademase Bovine, 25 IU
J2505	Pegfilgrastim (Neulasta), 6 mg
J2510	Penicillin G Procaine, Aqueous, up to 600,000 units
J2515	Pentobarbital Sodium, per 50 mg
J2540	Penicillin G Potassium (Pfizerpen), up to 600,000 units
J2545	Pentamidine Isethionate, inhalation solution, per 300 mg
J2550	Promethazine HCL (Phenergan), up to 50 mg
J2560	Phenobarbital Sodium, up to 120 mg
J2590	Oxytocin (Pitocin), up to 10 units
J2597	Desmopressin Acetate, per 1 mcg
J2650	Prednisolone Acetate, up to 1 ml
J2670	Tolazoline HCL (Priscoline HCL), up to 25 mg
J2675	Progesterone (injection), per 50 mg
J2680	Fluphenazine Decanoate (Prolixin Decanoate), up to 25 mg
J2690	Procainamide HCL (Pronestyl), up to 1 gm
J2700	Oxacillin Sodium (Prostaphlin), up to 250 mg
J2710	Neostigmine Methylsulfate (Prostigmin), up to 0.5 mg

CODE	DESCRIPTION
J2720	Protamine Sulfate, per 10 mg
J2730	Pralidoxime Chloride (Protopam Chloride), up to 1 gm
J2760	Phentolamine Mesylate (Regitine), up to 5 mg
J2765	Metoclopramide HCL (Reglan), up to 10 mg
J2780	Ranitidine HCL, 25 mg
J2783	Rasburicase, 0.5 mg
J2794	Risperidone, long acting, 0.5 mg
J2800	Methocarbamol (Robaxin), up to 10 ml
J2820	Sargramostim (GM-CSF), 50 mcg
J2910	Aurothioglucose (Solganal), up to 50 mg
J2912	Sodium Chloride, 0.9%, per 2 ml
J2920	Methylprednisolone Sodium Succinate (Solu-Medrol), up to 40 mg.
J2930	Methylprednisolone Sodium Succinate (Solu-Medrol), up to 125 mg
J2940	Somatrem, 1 mg
J2941	Somatropin, 1 mg
J2995	Streptokinase, per 250,000 IU
J3000	Streptomycin, up to 1 gm
J3030	Sumatriptan Succinate, 6 mg
J3070	Pentazocine (Talwin), 30 mg
J3105	Terbutaline Sulfate, up to 1 mg
J3120	Testosterone Enanthate, up to 100 mg
J3130	Testosterone Enanthate, up to 200 mg
J3140	Testosterone Suspension, up to 50 mg
J3150	Testosterone Propionate, up to 100 mg
J3230	Chlorpromazine HCL (Thorazine), up to 50 mg
J3240	Thyrotropin Alpha (Thyrogen), 0.9 mg. provided in 1.1 mg vial
J3250	Trimethobenzamide HCL (Tigan), up to 200 mg
J3260	Tobramycin Sulfate, (Nebcin) up to 80 mg
J3265	Torsemide, 10 mg/ml
J3280	Thiethylperazine Maleate (Torecan), up to 10 mg
J3285	Treprostinil, 1 mg
J3301	Triamcinolone Acetonide, per 10 mg
J3302	Triamcinolone Diacetate, per 5 mg
J3303	Triamcinolone Hexacetonide, per 5 mg
J3305	Trimetrexate Glucoronate, per 25 mg
J3310	Perphenazine (Trilafon), up to 5 mg
J3315	Triptorelin Pamoate, 3.75 mg
J3320	Spectinomycin Dihydrochloride (Trobicin), up to 2 gm
J3360	Diazepam (Valium), up to 5 mg
J3364	Urokinase, 5,000 IU vial
J3370	Vancomycin HCL, 500 mg
J3396	Verteporfin (Visudyne), 0.1 mg
J3400	Trifluprom azine HCL (Vesprin), up to 20 mg
J3410	Hydroxyzine HCL (Vistaril), up to 25 mg
J3411	Thiamine HCL, 100 mg
J3415	Pyridoxine HCL, 100 mg
J3420	Vitamin B-12 Cyanocobalamin, up to 1000 mcg
J3430	Phytonadione, (Vitamin K), per 1 mg

CODE	DESCRIPTION	
J3470	Hyaluronidase (Wydase), up to 150 Units	
J3475	Magnesium Sulfate, per 500 mg	
J3480	Potassium Chloride, per 2 mEq	
J3487	Zoledronic acid (Zometa), 1 mg	
J3520	Edetate Disodium, per 150 mg	
J3590	Unclassified Biologicals	BR

MISCELLANEOUS DRUGS AND SOLUTIONS

A4216	Sterile water, saline and/or dextrose (diluent), 10 ml	
A4218	Sterile saline or water, metered dose dispenser, 10 ml	
J7030	Infusion, normal saline solution (or water), 1000 cc	
J7040	Infusion, normal saline solution (or water), sterile (500 ml = 1 unit)	
J7042	5% dextrose/normal saline (500 ml = 1 unit)	
J7050	Infusion, normal saline solution (or water), 250 cc	
J7060	5% dextrose/water (500 ml = 1 unit)	
J7070	Infusion, D5W, 1000 cc	
J7100	Infusion, Dextran 40, 500 ml	
J7110	Infusion, Dextran 75, 500 ml	
J7120	Ringers Lacetate Infusion, up to 1000 cc	
J7130	Hypertonic saline solution, 50 or 100 mEq, 20 cc vial	
J7300	Intrauterine Copper Contraceptive	
J7302	Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 mg	
J7303	Contraceptive Supply, hormone containing vaginal ring, each	
J7304	Contraceptive Supply, hormone containing patch, each	
J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies	
J7308	Aminolevulinic Acid HCl for topical administration, 20%, single unit dosage form (354 mg)	
J7317	Sodium Hyaluronate (Hyalgan), per 20-25 mg dose for intra-articular injection	
J7320	Hylan G-F 20 (Synvisc), 16 mg, for intra-articular injection	
J7340	Dermal and Epidermal, (substitute) tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements, per sq. cm.	BR
J7341	Dermal (substitute) tissue of non-human origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter	
J7342	Dermal (substitute) tissue of human origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter	
J7501	Azathioprine, parenteral (eg Imuran), 100 mg	
J7504	Lymphocyte Immune Globulin, anti-thymyocyte globulin equine, parenteral, 250 mg	
J7611	Albuterol, inhalation solution, administered through DME, concentrated form, 1 mg	
J7612	Levalbuterol, inhalation solution, administered through DME, concentrated form 0.5 mg	
J7613	Albuterol, inhalation solution, administered through DME, unit dose 1 mg	
J7614	Levalbuterol, inhalation solution, administered through DME, unit dose 0.5 mg	
J7620	Albuterol, up to 2.5 mg and Ipratropium Bromide, up to 0.5 mg, non-compounded inhalation solution, administered through DME	

CODE	DESCRIPTION	
J7627	Budesonide, powder, compounded for inhalation solution, administered through DME, unit dose form, up to 0.5 mg	
J7628	Bitolterol Mesylate, inhalation solution, concentrated form, per mg	
J7631	Cromolyn sodium, inhalation solution, unit dose form, per 10 mg	
J7640	Formorterol, inhalation solution administered through DME, unit dose form, 12 mcg	
J7644	Ipratropium Bromide, inhalation solution, unit dose form, per mg	
J7648	Isoetharine HCL, inhalation solution, concentrated form, per mg	
J7649	Isoetharine HCL, inhalation solution, unit dose form, per mg	
J7658	Isoproterenol HCL, inhalation solution, concentrated form, per mg	
J7668	Metaproterenol Sulfate, inhalation solution, concentrated form, per 10 mg	
J7669	Metaproterenol Sulfate, inhalation solution, unit dose form, per 10 mg	
J7674	Methacholine Chloride administered as inhalation solution through a nebulizer, per 1 mg	
J7682	Tobramycin, unit dose form, 300 mg, inhalation solution	
J8501	Aprepitant, oral, 5 mg	
L8603	Injectable Bulking Agent, Collagen Implant, Urinary Tract, 2.5 ml syringe, includes shipping and necessary supplies	BR
S0190	Mitepristone, oral, 200 mg (when administered for medically necessary non-surgical abortion)	
S0191	Misoprostol, oral, 200 mcg (when administered for medically necessary non-surgical abortion)	
S9435	Medical foods for inborn errors of metabolism (reimbursement limited to Inborn Metabolic Disease Centers or Medical Directors of Inborn Metabolic Disease Centers)	BR
Q3031	Collagen Skin Test	BR
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	BR

CODE	DESCRIPTION	

CHEMOTHERAPY ADMINISTRATION

Procedures 96405-96549 are independent of the patient's office visit. Either may occur independently from the other on any given day, or they may occur sequentially on the same day. Intravenous chemotherapy injections are administered by a physician, a nurse practitioner or by a qualified assistant under supervision of the physician or nurse practitioner. Preparation of chemotherapy agent(s) is included in the service for administration of the agent.

Regional (isolation) chemotherapy perfusion should be reported using the codes for arterial infusion (96420-96425). Placement of the intra-arterial catheter should be reported using the appropriate code from the Cardiovascular Surgery section. Placement of arterial and venous cannula(s) for extracorporeal circulation via a membrane oxygenator perfusion pump should be reported using code 38623. Code 36823 includes dose calculation and administration of the chemotherapy agent by injection into the perfusate. Do not report code(s) 96409-96425 in conjunction with code 36823.

Report separate codes for each parenteral method of administration employed when chemotherapy is administered by different techniques. Medications (eg, antibiotics, steroidal agents, antiemetics, narcotics, analgesics, biological agents) administered independently or sequentially as supportive management of chemotherapy administration, should be separately reported using 90760-90768, as appropriate.

96405	Chemotherapy administration, intralesional; up to and including 7 lesions	10.00
96406	intralesional, more than 7 lesions	15.00
96409	intravenous; push technique, single or initial substance/drug	15.00
96413	Chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug	35.00
96415	each additional hour, 1 to 8 hours (List separately in addition to primary procedure) (Report 96415 for infusion intervals of greater than 30 minutes beyond 1-hour increments)	5.00
96416	initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	35.00
96420	Chemotherapy administration, intra-aryerial; push technique	
96422	infusion technique, up to one hour	35.00
96423	infusion technique, each additional hour up to 8 hours (List separately in addition to primary procedure) (Use 96423 in conjunction with code 96422)	5.00
96425	infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	35.00
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	47.00
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	47.00

CODE	DESCRIPTION	
96450	Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture (For intravesical (bladder) chemotherapy administration, see 51720) (For intraventricular catheter and reservoir, see 61210, 61215) (For insertion of subarachnoid catheter and reservoir for infusion of drug, see 62350, 62351, 62360, 62361, 62362)	42.00
96521	Refilling and maintenance of portable pump	15.00
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery systemic (eg, intravenous, intra-arterial) (Access of pump port is included in filling of implantable pump)	15.00
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	15.00
96549	Unlisted chemotherapy procedure	BR
J9999	Not otherwise classified, antineoplastic drugs	BR

CHEMOTHERAPY DRUGS

(Maximum fee is for chemotherapy drug only and does not include the administration fees as listed above)

NOTE: The maximum fees for these drugs are adjusted periodically by the State to reflect the estimated acquisition cost. Insert actual acquisition cost per dose in amount charged field on claim form. For codes listed BR, also attach itemized invoice to claim form.

Reimbursement for drugs 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.

J0128	Abarelix, 10 mg
J9000	Doxorubicin HCL (Adriamycin), 10 mg
J9001	Doxorubicin Hydrochloride, all lipid formulations, 10 mg
J9010	Alemtuzumab, 10 mg
J9015	Aldesleukin, per single use vial
J9017	Arsenic Trioxide (Trisenox), 1 mg
J9020	Asparaginase (Elspar), 10,000 units
J9025	Azacitidine, 1 mg
J9027	Clofarabine, 1 mg
J9031	BCG live (intravesical), per installation
J9035	Bevacizumab, 10 mg
J9040	Bleomycin Sulfate (Lenoxane), 15 units

CODE	DESCRIPTION	
J9041	Bortezomib, 0.1 mg	
J9045	Carboplatin, 50 mg	
J9050	Carmustine, 100 mg	
J9055	Cetuximab, 10 mg	
J9060	Cisplatin (Platinol), powder or solution, per 10 mg	
J9062	Cisplatin (Platinol), 50 mg	
J9065	Cladribine, per 1 mg	
J9070	Cyclophosphamide (Cytoxan, Neosar), 100 mg	
J9080	Cyclophosphamide (Cytoxan, Neosar), 200 mg	
J9090	Cyclophosphamide (Cytoxan, Neosar), 500 mg	
J9091	Cyclophosphamide (Cytoxan, Neosar), 1 gm	
J9092	Cyclophosphamide (Cytoxan, Neosar), 2 gm	
J9093	Cyclophosphamide, Lyophilized (Cytoxan), 100 mg	
J9094	Cyclophosphamide, Lyophilized (Cytoxan), 200 mg	
J9095	Cyclophosphamide, Lyophilized (Cytoxan), 500 mg	
J9096	Cyclophosphamide, Lyophilized (Cytoxan), 1 gm	
J9097	Cyclophosphamide, Lyophilized (Cytoxan), 2 gm	
J9098	Cytarabine Liposome, 10 mg	
J9100	Cytarabine (Cytosar-U), 100 mg	
J9110	Cytarabine (Cytosar-U), 500 mg	
J9120	Dactinomycin (Cosmegen), 0.5 mg	
J9130	Dacarbazine, 100 mg	
J9140	Dacarbazine, 200 mg	
J9150	Daunorubicin HCL, 10 mg	
J9151	Daunorubicin Citrate, liposomal formulation, 10 mg	
J9160	Denileukin Diftitox, 300 mcg	
J9165	Diethylstilbestrol Diphosphate, 250 mg	
J9170	Docetaxel, 20 mg	
J9175	Elliotts' B solution, 1 ml	BR
J9178	Epirubicin HCL, 2 mg	
J9181	Etoposide, 10 mg	
J9182	Etoposide, 100 mg	
J9185	Fludarabine Phosphate, 50 mg	
J9190	Fluorouracil, 500 mg	
J9200	Floxuridine (FUDR), 500 mg	
J9201	Gemcitabine HCL, 200 mg	
J9202	Goserelin Acetate Implant per 3.6 mg	
J9206	Irinotecan, 20 mg	
J9208	Ifosfomide, 1 gm	
J9209	Mesna, 200 mg	
J9211	Idarubicin Hydrochloride, 5 mg	
J9212	Interferon Alfacon-1, Recombinant, 1 mcg	
J9213	Interferon, Alfa-2A, Recombinant, 3 million units	
J9214	Interferon, Alfa-2B, Recombinant, 1 million units	
J9215	Interferon, Alfa-N3, (Human Leukocyte Derived), 250,000 IU	
J9216	Interferon, Gamma 1-B, 3 million units	
J9217	Leuprolide Acetate (for Depot Suspension), 7.5 mg	
J9218	Leuprolide Acetate, per 1 mg	

CODE	DESCRIPTION	
J9219	Leuprolide Acetate Implant, 65 mg	
J9225	Histrelin Implant, 50 mg	
J9230	Mechlorethamine Hydrochloride (Nitrogen Mustard), 10 mg	
J9245	Melphalan Hydrochloride, 50 mg	
J9250	Methotrexate Sodium, 5 mg	
J9260	Methotrexate Sodium, 50 mg	
J9263	Oxaliplatin (Eloxatin), 0.5 mg	
J9264	Paclitaxel protein-bound particles, 1 mg	
J9265	Paclitaxel, 30 mg	
J9266	Pegaspargase, per single dose vial	
J9268	Pentostatin, per 10 mg	
J9270	Plicamycin, 2.5 mg	
J9280	Mitomycin, 5 mg	
J9290	Mitomycin, 20 mg	
J9291	Mitomycin, 40 mg	
J9293	Mitoxantrone Hydrochloride, per 5 mg	
J9300	Gemtuzumab Ozogamicin, 5 mg	
J9305	Pemetrexed, 10 mg	
J9310	Rituximab, 100 mg	
J9320	Streptozocin, 1 gm	
J9340	Thiotepa, 15 mg	
J9350	Topotecan, 4 mg	
J9355	Trastuzumab, 10 mg	
J9357	Valrubicin, intravesical, 200 mg	
J9360	Vinblastine Sulfate, 1 mg	
J9370	Vincristine Sulfate, 1 mg	
J9375	Vincristine Sulfate, 2 mg	
J9380	Vincristine Sulfate, 5 mg	
J9390	Vinorelbine Tartrate, per 10 mg	
J9395	Fulvestrant (Faslodex), 25 mg	
J9600	Porfimer Sodium, 75 mg	
J9999	Not Otherwise Classified, Antineoplastic Drugs	BR
Q0165	Prochlorperazine Maleate, 10 mg, oral	
Q0174	Thiethylperazine Maleate, 10 mg, oral	
Q0177	Hydroxyzine Pamoate, 25 mg, oral	
Q2017	Teniposide, 50 mg	

CODE	DESCRIPTION	FEE

PSYCHIATRY

Codes 90801-90899 are for face-to-face services provided by a Psychiatrist.

Hospital care by the attending physician in treating a psychiatric inpatient or partial hospitalization may be initial or subsequent in nature (see 99221-99233) and may include exchanges with nursing and ancillary personnel. Hospital care services involve a variety of responsibilities unique to the medical management of inpatients, such as physician hospital orders, interpretation of laboratory or other medical diagnostic studies and observations, review of activity therapy reports, supervision of nursing and ancillary personnel, and the programming of all hospital resources for diagnosis and treatment. Some patients receive hospital evaluation and management services only and others receive evaluation and management services and other procedures. If other procedures such as electroconvulsive therapy are rendered by the physician in addition to hospital evaluation and management services, these should be listed separately (ie, hospital care service plus electroconvulsive therapy).

Other evaluation and management services, such as office medical services or other patient encounters, may be described as listed in the section on Evaluation and Management, if appropriate. The Evaluation and Management services should not be reported separately, when reporting codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829.

When reporting procedure codes 90801, 90802, 90846, 90847, 90849, 90853, 90857, 90862 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount. The amount billed should reflect total amount due. (When billing for procedure codes 90804 through 90857, 96101, the total time billed to New York State Medicaid should reflect the face-to-face contact time with the patient. Reimbursement for all work performed before and after the face-to-face encounter (eg, analysis of tests, reviewing records, etc.) is included in the maximum reimbursable amount for the face-to-face encounter.) More information on the definition of time, specifically the definition of face-to-face contact time can be found under General Information and Rules in the Medicine Section.

PSYCHIATRIC DIAGNOSTIC OR EVALUATIVE INTERVIEW PROCEDURES

Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants will be seen in lieu of the patient.

Interactive psychiatric diagnostic interview examination is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.

90801	Psychiatric diagnostic interview examination	45.00

CODE	DESCRIPTION	FEE
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication	45.00

PSYCHIATRIC THERAPEUTIC PROCEDURES

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy; and Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy.

Interactive psychotherapy is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.

Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.

Some patients receive psychotherapy only and other receive psychotherapy and medical evaluation and management services. These evaluation and management services involve a variety of responsibilities unique to the medical management of psychiatric patients, such as medical diagnostic evaluation (eg, evaluation of comorbid medical conditions, drug interactions, and physical examinations), drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations.

In reporting psychotherapy, the appropriate code is chosen on the basis of the type of psychotherapy (interactive using non-verbal techniques versus insight oriented, behavior modifying and/or supportive using verbal techniques), the place of service (office versus inpatient), the face-to-face time spent with the patient during psychotherapy, and whether evaluation and management services are furnished on the same date of service as psychotherapy.

To report medical evaluation and management services furnished on a day when psychotherapy is not provided, select the appropriate code from the **Evaluation and Management Services Guidelines.**

OFFICE INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE PSYCHOTHERAPY

90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an **office** (practitioner's office), approximately 20 to 30 minutes (greater than 20 minutes but less than 37 minutes) face-to-face with the patient;	27.00
90805	with medical evaluation and management services	27.00

CODE	DESCRIPTION	FEE
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an **office** (practitioner's office), approximately 45 to 50 minutes (37 minutes to 1 hour)face-to-face with the patient;	54.00
90807	with medical evaluation and management services	54.00
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an **office** (practitioner's office), approximately 75 to 80 minutes (greater than 1 hour) face-to-face with the patient **(Report Required);**	81.00
90809	with medical evaluation and management services **(Report Required)**	81.00

INTERACTIVE PSYCHOTHERAPY

90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpretor or other mechanisms of non-verbal communication, in an **office** (practitioner's office), approximately 20 to 30 minutes (greater than 20 minutes but less than 37 minutes) face-to-face with the patient;	27.00
90811	with medical evaluation and management services	27.00
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpretor, or other mechanisms of non-verbal communication, in an **office** (practitioner's office), approximately 45 to 50 minutes (37 minutes to 1 hour) face-to-face with patient;	54.00
90813	with medical evaluation and management services	54.00
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpretor, or other mechanisms of non-verbal communication, in an **office** (practitioner's office), approximately 75 to 80 minutes (greater than 1 hour) face-to-face with the patient;**(Report Required)**	81.00
90815	with medical evaluation and management services **(Report Required)**	81.00

INPATIENT OR OUTPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE FACILITY; INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE PSYCHOTHERAPY

90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an **inpatient or outpatient** hospital, partial hospital or residential care setting, approximately 20 to 30 minutes (greater than 20 minutes but less than 37 minutes) face-to-face with the patient;	22.50
90817	with medical evaluation and management services	22.50
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an **inpatient or outpatient** hospital, partial hospital or residential care setting, approximately 45 to 50 minutes (37 minutes to 1 hour) face-to-face with the patient;	45.00
90819	with medical evaluation and management services	45.00

CODE	DESCRIPTION	FEE
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an **inpatient or outpatient** hospital, partial hospital or residential care setting, approximately 75 to 80 minutes (greater than 1 hour) face-to-face with the patient **(Report Required)**;	67.50
90822	with medical evaluation and management services **(Report Required)**	67.50

INTERACTIVE PSYCHOTHERAPY

90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpretor, or other mechanisms of non-verbal communication in an **inpatient or outpatient** hospital, partial hospital or residential care setting, approximately 20 to 30 minutes (greater than 20 minutes but less than 37 minutes) face-to-face with the patient;	22.50
90824	with medical evaluation and management services	22.50
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpretor, or other mechanisms of non-verbal communication in an **inpatient or outpatient** hospital, partial hospital or residential care setting, approximately 45 to 50 minutes (37 minutes to 1 hour) face-to-face with the patient;	45.00
90827	with medical evaluation and management services	45.00
90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpretor, or other mechanisms of non-verbal communication in an **inpatient or outpatient** hospital, partial hospital or residential care setting, approximately 75 to 80 minutes (greater than 1 hour) face-to-face with the patient **(Report Required);**	67.50
90829	with medical evaluation and management services **(Report Required)**	67.50

OTHER PSYCHOTHERAPY

90846	Family psychotherapy (without patient present)	13.50
90847	Family psychotherapy (conjoint psychotherapy)(with patient present) (1 1/2 hours, per person; maximum 8 persons per group)	13.50
90849	Multiple-family group psychotherapy (1 1/2 hours, per person; maximum 8 persons per group)	13.50
90853	Group psychotherapy (other than of a multiple-family group) (1 1/2 hours, per person; maximum 8 persons per group)	13.50
90857	Interactive group psychotherapy (1 1/2 hours, per person; maximum 8 persons per group)	13.50

OTHER PSYCHIATRIC SERVICES OR PROCEDURES

90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (Do not report code 90862 in addition to Evaluation and Management codes 99201-99440 or Psychiatry codes 90801-90899)	22.50
90870	Electroconvulsive therapy (includes necessary monitoring)	45.00
90899	Unlisted psychiatric service or procedure	BR

PSYCHIATRIC SOCIAL WORKER VISITS

For dates of service on or after July 1, 2002, report services provided by a Certified Social Worker (CSW) under the direct supervision of an employing psychiatrist, using the following procedure codes and maximum reimbursable amounts: 90804 ($13.50), 90806 ($27.00), 90846 ($7.20), 90847 ($7.20), 90849 ($7.20), 90853 ($7.20), 90857 ($7.20). See modifier – AJ. (For services provided prior to July 1, 2002, continue to use procedure codes W0092-W0095.)

DIALYSIS PROCEDURES

Professional dialysis fees for physician in personal attendance. See SURGERY Section for corresponding surgical procedures.

Codes 90918-90921 are reported ONCE per month to distinguish age-specific services related to the patient's end-stage renal disease (ESRD) performed in an outpatient setting. ESRD related physician services include establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visits, telephone calls, and patient management during the dialysis, provided during a full month. These codes are not used if hospitalization occurred during the month.

Codes 90918-90921 do not include the dialysis treatment (90935, 90937, 90945, 90947) or any non-ESRD related services or other patient care services rendered outside of the dialysis setting during that month.

Evaluation and management services unrelated to ESRD services that cannot be performed during the dialysis session may be reported separately.

Codes 90922-90925 are reported when outpatient ESRD related services are not performed consecutively during an entire full month. Codes 90922-90925 are used to report ESRD related services on a per day basis, one claim line is used prorating the number of days X the fee listed, the total number of days should be entered in the "Days or Units" field. The codes can be used preceding and/or following the period of hospitalization.

EXAMPLE: A four year old receiving continuous peritoneal dialysis has sixteen days of daily outpatient care, preceding or following a period of hospitalization.

Report 90923 for each date outpatient care was performed.

For ESRD related services and dialysis procedure(s) performed during period of hospitalization: Report appropriate Hospital Evaluation and Management Services code(s) for the hospitalized period if service(s) is unrelated to ESRD services. Report 90945 or 90947 for each inpatient dialysis procedure.

END STAGE RENAL DISEASE SERVICES

90918	End stage renal disease (ESRD) related services per full month; for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	52.00
90919	for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	52.00

CODE	DESCRIPTION	FEE
90920	End stage renal disease (ESRD) related services per full month;for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	52.00
90921	for patients 20 years of age and over	52.00
90922	End stage renal disease (ESRD) related services (less than full month), per day; for patients under 2 years of age	1.73
90923	for patients between 2 and 11 years of age	1.73
90924	for patients between 12 and 19 years of age	1.73
90925	for patients 20 years of age and over	1.73

HEMODIALYSIS

Codes 90935, 90937 are reported to describe the hemodialysis procedure with all evaluation and management services related to the patient's renal disease on the day of the hemodialysis procedure. These codes are used for inpatient ESRD and non-ESRD procedures or for outpatient non-ESRD dialysis services. Code 90935 is reported if only one evaluation of the patient is required related to that hemodialysis procedure. Code 90935 is reported if only one evaluation of the patient is required related to that hemodialysis procedure. Code 90937 is reported when patient re-evaluation(s) is required during a hemodialysis procedure. Utilize the modifier -25 with Evaluation and Management codes for separately identifiable services unrelated to the dialysis procedure or renal failure which cannot be rendered during the dialysis session.

(For cannula declotting, see 36831, 36833, 36860, 36861)

(For declotting of implanted vasvular access device or catheter by thrombolytic agenct, use 36550)

(For collection of blood specimen from a partially or completely implantable venous access device, use 36540)

90935	Hemodialysis procedure with single physician evaluation	7.50
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	7.50

MISCELLANEOUS DIALYSIS PROCEDURE

(For insertion of intraperitoneal cannula or catheter, see 49420, 49421)

90945	Dialysis procedure other than hemodialysis(eg, peritoneal dialysis, hemofiltration or other continuous renal replacement therapies), with single physician evaluation	75.00
90947	Dialysis procedure other than hemodialysis(eg, peritoneal dialysis, hemofiltration or other continuous renal replacement therapies), requiring repeated physician evaluations, with or without substantial revision of dialysis prescription	75.00
90999	Unlisted dialysis procedure, inpatient or out-patient	BR

CODE	DESCRIPTION	FEE

GASTROENTEROLOGY

(For gastrointestinal radiologic procedures, see 74210-74363)

(For esophagoscopy procedures, see 43200-43228; upper GI endoscopy 43234-43259; endoscopy, small bowel and stomal 44360-44393; proctosigmoidoscopy 45300-45321; sigmoidoscopy 45330-45339; colonoscopy 45355-45385; anoscopy 46600-46615)

(For gastric biopsy by capsule, tube, peroral, see 43600)

(For small intestine biopsy by capsule, tube, peroral, see 44100)

(For peritoneoscopy and guided transhepatic cholangiogrpahy, use 47560; with biopsy, use 47561)

(For splenoportography, see 38200, 75810)

91000	Esophageal intubation and collection of washing for cytology, including preparation of specimens preparation of specimens	60.00
91010	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study;	50.00
91011	with mecholyl or similar stimulant	50.00
91012	with acid perfusion studies	50.00
91020	Gastric motility (manometric) studies	50.00
91022	Duodenal motility (manometric) study	50.00
91030	Esophagus, acid perfusion (Bernstein) test for esophagitis	60.00
91037	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation	35.00
91038	prolonged (greater than 1 hour, up to 24 hours)	35.00
91040	esophageal balloon distension provocation study	BR
91052	Gastric analysis test with injection of stimulant of gastric secretion (eg, histamine, insulin, pentagastrin, calcium and secretin)	BR
91055	Gastric intubation, washings, and preparing slides for cytology (separate procedure)	60.00
91060	Gastric saline load test	50.00
91065	Breath hydrogen test (eg, for detection of lactase deficiency), frutcose intolerance; bacterial overgrowth, or oro-cecal gastrointestinal transit	25.00
91100	Intestinal bleeding tube, passage, positioning and monitoring	25.00
91105	Gastric intubation, and aspiration or lavage for treatment (eg, for ingested poisons)	10.00
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report	800.00
91120	Rectal sensation, tone, and compliance test (ie, response to graded balloon distention)	BR
91122	Anorectal manometry	50.00
91299	Unlisted diagnostic gastroenterology procedure	BR

OPHTHALMOLOGY

OPHTHALMOLOGICAL DIAGNOSTIC AND TREATMENT SERVICES

(For surgical procedures, see 65091 et seq)

REPORTING

See MEDICINE General Information and Rules and special ophthalmology notations below.

To report Evaluation and Management services, wherever performed, use descriptors from the Evaluation and Management Services for Specialists in Ophthalmology listing (99201 et seq).

To report intermediate, comprehensive and special services, use the specific ophthalmological descriptors (92002 et seq).

To report hospital and emergency department medical services, use the descriptors from the Evaluation and Management Services for Specialists in Ophthalmology listing (99221 et seq) unless specific ophthalmological descriptors (92002 et seq) are more appropriate.

DEFINITIONS:

INTERMEDIATE OPHTHALMOLOGICAL SERVICES: A level of service pertaining to the evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated; may include the use of mydriasis. Intermediate services in a new patient do not usually include determination of the refractive state but do so in an established patient (92012) who is under continuing active treatment (eg, review of history, external examination, ophthalmoscopy, biomicroscopy for an acute complicated condition (eg, iritis) not requiring comprehensive ophthalmological services or review of interval history, external examination, ophthalmoscopy, biomicroscopy and tonometry in established patient with known cataract not requiring comprehensive ophthalmological services))

COMPREHENSIVE OPHTHALMOLOGICAL SERVICES: A level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated; biomicroscopy, examination with cycloplegia or mydriasis, tonometry, and includes determination of the refractive state, unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation. It always includes initiation of diagnostic and treatment programs as indicated.

(eg, the comprehensive services required for diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract or retinal disease, or to rule out disease of the visual system, new or established patient)

"Initiation of diagnostic and treatment program" includes the prescription of medication, lenses and other therapy and arranging for special ophthalmological diagnostic or treatment services, consultations, laboratory procedures and radiological services as may be indicated.

Prescription of lenses may be deferred to a subsequent visit, but in any circumstance is not reported separately. ("Prescription of lenses" does not include anatomical facial measurements for or writing of laboratory specifications for spectacles; for spectacle services, see 92340 et seq).

DETERMINATION OF THE REFRACTIVE STATE: is the quantitative procedure that yields the refractive data necessary to determine the best visual acuity with lenses and to prescribe lenses. It is not a separate medical procedure, or service entity, but is an integral part of the general ophthalmological services, carried out with reference to other diagnostic procedures. The evaluation of the need for and the prescription of lenses is never based on the refractive state alone. Determination of the refractive state is not reported separately.

SPECIAL OPHTHALMOLOGICAL SERVICES: Services in which a special evaluation of part of the visual system is made, which goes beyond the services usually included under general ophthalmological services, or in which special treatment is given (eg, fluorescein angioscopy or quantitative visual field examination) should be specifically reported as special ophthalmological services.

Medical diagnostic evaluation by the physician is an integral part of all Ophthalmological services. Technical procedures (which may or may not be performed by the physician personally) are often part of the service, but should not be mistaken to constitute the service itself.

Intermediate and comprehensive ophthalmological services constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. Itemization of service components, such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, determination of refractive state, tonometry, motor evaluation, etc. is not applicable.

PRESCRIBING OF POLYCARBONATE LENS(ES): The prescriber must maintain documentation in the recipient's clinical file of the recipient's systemic ailments and ocular pathology which relate to the medical need for one or more polycarbonate lens(es).

GENERAL OPHTHALMOLOGICAL SERVICES

The designation of new or established patient does not preclude the use of a specific level of service. For Evaluation and Management services see 99201 et seq.

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific CPT code(s).

NEW PATIENT: A new patient is one who has not received any professional services from the physician within the past three years.

92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	30.00
92004	comprehensive, new patient (includes refraction)	30.00

CODE	DESCRIPTION	FEE

ESTABLISHED PATIENT: An established patient is one who has received professional services from the physician within the past three years and whose medical and administrative records are available to the physician.

92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient (includes refraction)	30.00
92014	comprehensive, established patient (includes refraction)	30.00

SPECIAL OPHTHALMOLOGICAL SERVICES

		ANES	
92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete	3.0+T	24.00
92019	limited	3.0+T	24.00
92020	Gonioscopy (separate procedure)	3.0+T	8.00
92060	Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)		15.00
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation		8.00
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)		8.00
92082	intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)		8.00
92083	extended examination, (eg, Goldmann visual fields with a least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)		8.00
	(Gross visual field testing (eg, confrontation testing) is a part of general ophthalmological services and is not reported separately.)		
92100	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)		4.00
92120	Tonography with interpretation and report, recording indentation tonometer method or perilimbal suction method		8.00
92130	Tonography with water provocation		16.00
92135	Scanning computerized ophthalmic diagnostic imaging (eg, scanning laser) with interpretation and report, unilateral		16.00

CODE	DESCRIPTION	FEE
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation	22.00
92140	Provocative tests for glaucoma, with interpretation and report, without tonography	8.00

OPHTHALMOSCOPY

Routine ophthalmoscopy is part of general and special ophthalmologic services whenever indicated. It is a non-itemized service and is not reported separately.

(For ophthalmoscopy under general anesthesia, see 92018)

92225	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), (one or both eyes), with interpretation and report; initial	15.00
92226	subsequent	15.00
92230	Fluorescein angioscopy with interpretation and report (one or both eyes)	BR
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report	50.00
92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report	50.00
92250	Fundus photography with interpretation and report	16.00
92260	Ophthalmodynamometry	25.00

OTHER SPECIALIZED SERVICES

Color vision testing with pseudoisochromatic plates is not reported separately. It is included in the appropriate general or ophthalmologic service.

(For electronystagmography for vestibular function studies, see 92541 et seq)

(For ophthalmic echography, see 76511-76529)

92265	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report	35.00
92270	Electro-oculography with interpretation and report	25.00
92275	Electroretinography with interpretation and report	35.00
92286	Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count	8.00
92287	with fluorescein angiography	BR

CONTACT LENS SERVICES

The prescription and fitting of contact lens includes specification of optical and physical characteristics (such as power, size, curvature, flexibility, gas-permeability) and includes instruction and training of the wearer and incidental revision of the lens during the training period. It is not a part of the general ophthalmological services. Contact lenses may be supplied for the treatment of ocular pathology. A written recommendation or prescription by an ophthalmologist or optometrist is always required for contact lenses. The ophthalmologist or optometrist may also fit and dispense contact lenses.

CODE	DESCRIPTION	FEE

The prescriber must maintain the following documentation in the recipient's clinical file:

- A description of the ocular pathology or medical necessity which provides justification for the recipient's need for contact lenses;
- The best corrected vision both with and without eyeglasses;
- The best corrected vision both with and without contact lenses;
- The refractive error; and
- The date of the last complete eye exam.

92310	Prescription of optical and physical characteristics of and fitting of contact lens, (includes materials) with medical supervision of adaptation (for ocular pathology) ; corneal lens, both eyes, except for aphakia (Reimbursement for one eye is limited to $150.00)	250.00
92311	corneal lens for aphakia, one eye	150.00
92312	corneal lens for aphakia, both eyes	250.00
92313	corneoscleral lens, one eye	125.00
92326	Replacement of corneal contact lens	65.00
	(For surgical use of contact lens, see 68340)	

OCULAR PROSTHETICS, ARTIFICIAL EYE

V2623	Prosthetic eye, plastic, custom (includes fitting and supply of ocular prosthesis and clinical supervision of adaptation)	2,000.00
V2624	Polishing/resurfacing of ocular prosthesis	37.00
V2625	Enlargement of ocular prosthesis	200.00
V2626	Reduction of ocular prosthesis	150.00
V2627	Scleral cover shell (when prescribed as an artificial support to a shrunken and sightless eye or as barrier in treatment of severe dry eye) (includes supply of shell, fitting and clinical supervision of adaptation)	2,000.00

SPECTACLE SERVICES (INCLUDING PROSTHESIS FOR APHAKIA)

Prescription of spectacles, when required, is an integral part of general ophthalmological services and is not reported separately. It includes specification of lens type (monofocal, bifocal, other), lens power, axis prism, absorptive factor, impact resistance, and other factors.

Fitting of spectacles is a separate service; when provided by the physician, it is reported as indicated by 92340-92358. Fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of the spectacles to the visual axes and anatomical topography. Presence of physician is not required.

Supply of materials is a separate service component; it is not part of the service of fitting spectacles.

CODE	DESCRIPTION	FEE
92340	Fitting of spectacles, except for aphakia; monofocal	4.00
92341	bifocal	4.00
92342	multifocal, other than bifocal	4.00
92352	Fitting of spectacle prosthesis for aphakia; monofocal	4.00
92353	multifocal	4.00
92354	Fitting of spectacle mounted low vision aid; single element system	4.00
92355	telescopic or other compound lens system	4.00
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)	14.50

SUPPLY OF MATERIALS

Supply of contact lenses and prosthetics is included in codes 92310-V2627.

99070	Supply of spectacles, except prosthesis for aphakia and low vision aids, Supply of low vision aids (a low vision aid is any lens or device used to aid or improve visual function in a person whose vision cannot be normalized by conventional spectacle correction, includes reading additions up to 4 D.), Supply of permanent prosthesis for aphakia; spectacles. (For temporary spectacle correction for aphakia, see 92358)	BR

OTHER PROCEDURES

92499	UNLISTED ophthalmological service or procedure	BR

CODE	DESCRIPTION	ANES	FEE

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic evaluation or office visit, are reported as an integrated medical service, using appropriate descriptors from the 99201 series. Itemization of component procedures, eg, otoscopy, rhinoscopy, tuning fork test, does not apply.

Special otorhinolaryngologic services are those diagnostic and treatment services not usually included in a comprehensive otorhinolaryngologic evaluation or office visit. These services are reported separately, using descriptors from the 92500 series.

All services include medical diagnostic evaluation. Technical procedures (which may or may not be performed by the physician personally) are often part of the service, but should not be mistaken to constitute the service itself.

92502	Otolaryngologic examination under general anesthesia	3.0+T	25.00
92511	Nasopharyngoscopy with endoscope (separate procedure)		40.00

VESTIBULAR FUNCTION TESTS, WITH OBSERVATION AND EVALUATION BY PHYSICIAN, WITHOUT ELECTRICAL RECORDING

92533	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)	15.00

VESTIBULAR FUNCTION TESTS, WITH RECORDING (EG, ENG, PENG), AND MEDICAL DIAGNOSTIC EVALUATION

92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	35.00
92542	Positional nystagmus test, minimum of 4 positions, with recording	35.00
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording	35.00
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	35.00
92545	Oscillating tracking test, with recording	10.00
92546	Sinusoidal vertical axis rotational testing	10.00

CODE	DESCRIPTION	FEE

AUDIOLOGIC FUNCTION TESTS WITH MEDICAL DIAGNOSTIC EVALUATION

The audiometric tests listed below imply the use of calibrated electronic equipment. Other hearing tests (such as whispered voice, tuning fork) are considered part of the general otorhinolaryngologic services and are not reported separately. All descriptors refer to testing of both ears.

92551	Screening test, pure tone, air only	5.00
92552	Pure tone audiometry(threshold); air only	5.00
92553	air and bone	10.00
92555	Speech audiometry threshold	5.00
92556	with speech recognition	15.00
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	25.00
92563	Tone decay test	5.00
92564	Short increment sensitivity index (SISI)	10.00
92565	Stenger test, pure tone	5.00
92567	Tympanometry (impedance testing)	10.00
92568	Acoustic reflex testing; threshold	10.00
92569	Acoustic reflex testing; decay	5.00
92571	Filtered speech test	25.00
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	90.00
92586	limited	25.00
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)	50.00
92588	comprehensive or diagnostic evaluation (comparsion of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)	69.00
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	24.00

(To report augmentative and alternative communication device services, see 92605, 92607, 92608)

EVALUATIVE AND THERAPEUTIC SERVICES

Codes 92601 and 92603 describe post-operative analysis and fitting of previously placed external devices, connection to the cochlear implant, and programming of the stimulator. Codes 92602 and 92604 describe subsequent sessions for measurements and adjustment of the external transmitter and re-programming of the internal stimulator.

(For placement of cochlear implant, use 69930)

92601	Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming	38.00
92602	subsequent reprogramming (Do not report 92602 in addition to 92601)	27.00

CODE	DESCRIPTION	FEE
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	26.00
92604	subsequent reprogramming (Do not report 92604 in addition to 92603)	18.00
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device	24.00
92606	Therapeutic service(s) for the use of non-speech generating device, including programming and modification	BR
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device,face-to-face with the patient; first hour	32.00
92608	each additional 30 minutes (List separately in addition to primary procedure) (Use 92608 in conjunction with 92607)	6.00
92609	Therapeutic services for the use of speech-generating device, including programming and modification	17.00
	(For therapeutic service(s) for the use of a non-speech generating device, use 92606)	
92610	Evaluation of oral and pharyngeal swallowing function	12.00
	(For motion fluoroscopic evaluation of swallowing function, use 92611) (For flexible endoscopic examination, use 92612-92617)	
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording (For radiological supervision and interpretation, use 74230)	13.00
	(For evaluation of oral and pharyngeal swallowing function, use 92610)	
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording	51.00
	(If flexible fiberoptic or endoscopic evaluation of swallowing is performed without cine or video recording, use 92700)	
92613	physician interpretation and report only	20.00
	(To report an evaluation of oral and pharyngeal swallowing function, use 92610) (To report motion fluoroscopic evaluation of swallowing function, use 92611)	
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording	39.00
92615	physician interpretation and report only	16.00
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording	53.00
92617	physician interpretation and report only	21.00
92700	Unlisted otorhinolaryngological service of procedure	BR

CARDIOVASCULAR

THERAPEUTIC SERVICES

(For placement of catheters for use in circulatory assist devices such as intra-aortic balloon pumping, see 33970)

(For stent placement following completion of angioplasty or atherectomy, see 92980, 92981)

CODE	DESCRIPTION	ANES	FEE
92950	Cardiopulmonary resuscitation (eg, in cardiac arrest) (each 15 minute unit of time) (see also critical care, 99291, 99292)	6.0+T	6.50
92953	Temporary transcutaneous pacing		5.00
92960	Cardioversion, elective, electrical conversion of arrhythmia; external (each 15 minute unit of time)	3.0+T	6.50
92961	internal (separate procedure) (Do not report 92961 in addition to codes 93662; 93618-93624, 93631, 93640-93642, 93650-93652, 93741-93744)	3.0+T	72.00
92970	Cardioassist-method of circulatory assist; internal		58.00
92971	external		30.00
92973	Percutaneous transluminal coronarythrombectomy (List separately in addition to primary procedure) (Use 92973 in conjunction with codes 92980, 92982)		52.00
92974	Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to primary procedure) (Use 92974 in conjunction with codes 92980, 92982, 93508)		59.00
	(For intravascular radioelement application, see 77781 – 77784)		
92975	Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiography		122.00
92977	by intravenous infusion		91.00
92978	Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel		81.00
92979	each additional vessel (Use 92979 in conjunction with code 92978)		50.00
	(List 92978, 92979 separately in addition to primary code) (Intravascular ultrasound services include all transducer manipulations and repositioning within the specific vessel being examined, both before and after therapeutic intervention (eg, stent placement))		

CODE	DESCRIPTION	F/U DAYS	FEE
92980	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel		349.00
92981	each additional vessel (Use 92981 in conjunction with code 92980)		109.00
92982	Percutaneous transluminal coronary balloon angioplasty; single vessel		250.00
92984	each additional vessel (Use 92984 in conjunction with code(s) 92980, 92982, 92995)		125.00
	(To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use 92974) (For intravascular radioelement application, see 77781-77784)		
92986	Percutaneous balloon valvuloplasty; aortic valve	90	372.00
92987	mitral valve	90	386.00
92990	pulmonary valve	90	400.00
92992	Atrial septectomy or septostomy; transvenous method, balloon, (eg, Rashkind type) (includes cardiac catheterization)	90	270.00
92993	blade method (Park septostomy) (includes cardiac catheterization)	90	270.00
92995	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel		218.00
92996	each additional vessel (Use 92996 in conjunction with code(s) 92980, 92982, 92995)		59.00
	(To report additional vessels treated by angioplasty only during the same session, use 92984)		
92997	Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel		215.00
92998	each additional vessel (List separately in addition to primary procedure)		99.00

CARDIOGRAPHY

(For echocardiology, see 93303-93350)

93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	15.00
93010	interpretation and report only	7.50
93014	Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), per 30 day period of time; **(complete procedure)** includes physician review with interpretation and report. (For professional component use modifier ‘26.)	60.00

CODE	DESCRIPTION	FEE
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, and/or pharmacological stress, with physician supervision, with interpretation and report	60.00
93016	physician supervision only without interpretation and report	16.50
93018	interpretation and report only	13.50
93024	Ergonovine provocation test	BR
93025	Microvolt T-wave alternans for assessment of ventricular arrhythmias	78.00
93040	Rhythm ECG, one to three leads; with interpretation and report	5.00
93224	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation	60.00
93227	physician review and interpretation	42.00
93230	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation	60.00
93233	physician review and interpretation	42.00
93235	Electrocardiographic monitoring for 24 hours by continuous computerized monitoring and non-continuous recording, and real-time data analysis utilizing a device capable of producing intermittent full-sized waveform tracings, possibly patient activated; includes monitoring and real time data analysis with report, physician review and interpretation	60.00
93237	physician review and interpretation	42.00
93268	Patient demand single or multiple event, recording with presymptom memory loop, 24 hour attended monitoring per 30-day period of time; **(complete procedure)** includes transmission, physician review and interpretation	60.00
93272	physician review and interpretation only	42.00
	(For implanted patient activated cardiac event recording, see 33282, 93727)	
93278	Signal-averaged electrocardiography (SAECG), with or without ECG (For interpretation and report only, see modifier -26)	60.00

ECHOCARDIOGRAPHY

For procedure codes 93303-93350, See Radiology Section General Instructions and General Information and Rules. When more than one radiology procedure is performed during the same patient encounter, reimbursement shall be limited to the greater fee plus 60% of the lesser fees. (Echocardiography includes obtaining ultrasonic signals from the heart and great arteries, with two-dimensional image and/or Doppler ultrasonic signal documentation, interpretation and report. When interpretation is performed separately, use modifier -26.)

(For fetal echocardiography, see 76825-76828)

CODE	DESCRIPTION	FEE
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	90.00
93304	follow-up or limited study	60.00
93307	Echocardiography, transthoracic, reaL time with image documentation (2D) with or without M-mode recording; complete	90.00
93308	follow-up or limited study	60.00
93312	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-Mode recording); including probe placement, image acquisition, interpretation and report	105.00
93313	placement of transesophagael probe only	25.00
93314	image acquisition, interpretation and report only	84.00
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	105.00
93316	placement of transesophageal probe only	25.00
93317	image acquisition, interpretation and report only	84.00
93318	Echocardiography, transesophageal (TEE) for montoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	100.00
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectra1 display; complete	87.00
93321	follow-up or limited study	60.00
	(Use 93320, 93321 separately in addition to codes for echocardiographic imaging 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93316, 93317, 93350)	
93350	Echocardiography, transthoracic, real time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report (The appropriate stress testing code from the 93015-93018 series should he reported in addition to 93350 to capture the exercise stress portion of the study)	120.00

CARDIAC CATHETERIZATION

Cardiac catheterization procedures include introduction, positioning and repositioning when necessary, of catheter(s), recording of intracardiac and intravascular pressure, obtaining blood samples for measurement of blood gases or dilution curves and cardiac output measurements (Fick or other method, with or without rest and exercise and/or other studies) with or without electrode catheter placement, final evaluation and report. When selective injection procedures are performed without a preceding cardiac catheterization, these services should be reported using codes in the Vascular Injection Procedures section, 36011-36015 and 36215-36218.

CODE	DESCRIPTION	F/U DAYS	FEE
	When coronary artery, arterial coronary conduit or venous bypass graft angiography is performed without concomitant left heart cardiac catheterization, use 93508. Injection procedures 93539, 93540, 93544, and 93545 represent separate identifiable services and may be coded in conjunction with one another in addition to code 93508, as appropriate. To report imaging supervision, interpretation and report in conjunction with code 93508, use code 93556.		
93501	Right heart catheterization (For bundle of His recording, see 93600)	7	140.00
93503	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes	7	140.00
93505	Endomyocardial biopsy	7	160.00
93508	Catheter placement in coronary artery(s), arterial coronary conduit(s); and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization (93508 is to be used only when left heart catheterization 93510, 93511, 93524, 93526 is not performed) (To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use 92974) (For intravascular radioelement application, see 77781-77784)	7	207.00
93510	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous	7	80.00
93511	by cutdown	7	80.00
93514	Left heart catheterization by left ventricular puncture	7	80.00
93524	Combined transseptal and retrograde left heart catheterization	7	160.00
93526	Combined right heart catheterization and retrograde left heart catheterization	7	180.00
93527	Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)	7	180.00
93528	Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)	7	140.00
93529	Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)	7	140.00
93530	Right heart catheterization, for congenital cardiac anomalies	7	140.00
93531	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	7	180.00
93532	Combined right heart catheterization and transseptal left heart catherization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies	7	180.00

CODE	DESCRIPTION	F/U DAYS	FEE
93533	Combined right heart catheterization and transseptal left heart catherization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies	7	180.00

When injection procedures are performed in conjunction with cardiac catheterization, these services do not include introduction of catheters but do include repositioning of catheters when necessary and use of automatic power injectors. Injection procedures 93539-93545 represent separate identifiable services and may be coded in conjunction with one another when appropriate. The technical details of angiography, supervision of filming and processing, interpretation and report are not included. To report imaging supervision, interpretation and report, use code 93555 and/or 93556.

		ANES	
93539	Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass	3.0+T	28.00
93540	for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries	3.0+T	28.00
93541	for pulmonary angiography	3.0+T	20.00
93542	for selective right ventricular or right atrial angiography	3.0+T	20.00
93543	for selective left ventricular or left atrial angiography	3.0+T	20.00
93544	for aortography	3.0+T	100.00
93545	for selective coronary angiography (injection of radiopaque material may be by hand)	3.0+T	20.00
93555	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography		81.00
93556	pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)		124.00

(Codes 93561 & 93562 are not to be used with cardiac catheterization codes)

93561	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)	25.00
93562	subsequent measurement of cardiac output	12.50

(For radioisotope method of cardiac output, see 78472, 78473 or 78481)

CODE	DESCRIPTION	F/U DAYS	FEE
93571	Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharacologically induced stress; initial vessel (List separately in addition to primary procedure)		80.00
93572	each additional vessel (List separately in addition to primary procedure)		50.00
	(Intravascular distal coronary blood flow velocity measurements include all Doopler transducer manipulations and repositioning within the specific vessel being examined, during coronary angioplasty or therapeutic intervention (eg, angioplasty))		

REPAIR OF SEPTAL DEFECT

CODE	DESCRIPTION	F/U DAYS	FEE
93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, fontan fenestration, atrial septal defect) with implant (Percutaneous transcatheter closure of atrial septal defect includes a right heart catheterization procedure. Code 93580 includes injection of contrast for atrial and ventricular angiograms. Codes 93501, 93529-93533, 93539, 93543, 93555 should not be reported separately in addition to code 93580)	7	285.00
93581	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant (Percutaneous transcatheter closure of ventricular septal defect includes a right heart catheterization procedure. Code 93581 includes injection of contrast for atrial and ventricular angiograms. Codes 93501, 93529-93533, 93539, 93543, 93555 should not be reported separately in addition to code 93581) (For echocardiographic services performed in addition to 93580, 93581, see 93303-93317, 93662 as appropriate)	7	381.00

INTRACARDIACELECTROPHYSIOLOGICAL PROCEDURES/STUDIES

Intracardiac electrophysiologic studies (EPS) are an invasive diagnostic medical procedure which include the insertion and repositioning of electrode catheters, recording of electrograms before and during pacing or programmed stimulation of multiple locations in the heart, analysis of recorded information, and report of the procedure.

Electrophysiologic studies are most often performed with two or more electrode catheters. In many circumstances, patients with arrhythmias are evaluated and treated at the same encounter. In this situation, a diagnostic *electrophysiologic study* is performed, induced tachycardia(s) are *mapped,* and on the basis of the diagnostic and mapping information, the tissue is *ablated*. Electrophysiologic study(ies), mapping, and ablation represent distinctly different procedures, requiring individual reporting whether performed on the same or subsequent dates.

CODE	DESCRIPTION	FEE

DEFINITIONS:

ARRHYTHMIA INDUCTION: In most electrophysiologic studies, an attempt is made to induce arrhythmia(s) from single or multiple sites within the heart. Arrhythmia induction is achieved by performing pacing at different rates, programmed stimulation (introduction of critically timed electrical impulses), and other techniques. Because arrhythmia induction occurs via the same catheter(s) inserted for the electrophysiologic study(ies), catheter insertion and temporary pacemaker codes are not additionally reported. Codes 93600-93603, 93610-93612 and 93618 are used to describe unusual situations where there may be recording, pacing or an attempt at arrhythmia induction from only one site in the heart. Code 93619 describes only evaluation of the sinus node, atrioventricular node and His-Purkinje conduction system, without arrhythmia induction. Codes 93620-93624 and 93640-93642 all include recording, pacing and attempted arrhythmia induction from one or more site(s) in the heart.

MAPPING: Mapping is a distinct procedure performed in addition to a diagnostic electrophysiologic procedure and should be separately reported using code 93609. When a tachycardia is induced, the site of tachycardia origination or its electrical path through the heart is often defined by mapping. Mapping creates a multidimensional depiction of a tachycardia by recording multiple electrograms obtained sequentially or simultaneously from multiple catheter sites in the heart. Depending upon the technique, certain types of mapping catheters may be repositioned from point-to-point within the heart, allowing sequential recording from the various sites to construct maps. Other types of mapping catheters allow mapping without a point-to-point technique by the allowing simultaneous recording from many electrodes on the same catheter and computer-assisted three dimensional reconstruction of the tachycardia activation sequence.

ABLATION: Once the part of the heart involved in the tachycardia is localized, the tachycardia may be treated by ablation (the delivery of a radiofrequency energy to the area to selectively destroy cardiac tissue). Ablation procedures (93651-93652) may be performed: independently on a date subsequent to a diagnostic electrophysiologic study and mapping; or, at the time a diagnostic electrophysiologic study, tachycardia(s) induction and mapping is performed. When an electrophysiologic study, mapping, and ablation are performed on the same date, each procedure should be separately reported. In reporting catheter ablation, code 93651 and/or 93652 should be reported once to describe ablation of cardiac arrhythmias, regardless of the number of arrhythmias ablated.

93600	Bundle of His recording	80.00
93602	Intra-atrial recording	56.00
93603	Right ventricular recording	67.00
93609	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to primary procedure) (Use 93609 in conjunction with codes 93620, 93651, 93652)	184.00
93610	Intra-atrial pacing	75.00
93612	Intraventricular pacing (Do not report 93612 in conjunction with codes 93620-93622)	78.00

CODE	DESCRIPTION	FEE
93615	Esophageal recording of atrial electrogram with or without ventricular electrogram(s);	18.00
93616	with pacing	35.00
93618	Induction of arrhythmia by electrical pacing	156.00
93619	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, HIS bundle recording, including insertion and repositioning of multiple electrode catheters; without induction or attempted induction of arrhythmia (Do not report 93619 in conjunction with 93600, 93602, 93610, 93612, 93618, or 93620-93622)	291.00
93620	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, HIS bundle recording (Do not report 93620 in conjunction with codes 93600, 93602, 93610 93612, 93618 or 93619)	383.00
93621	with left atrial pacing and recordings from coronary sinus or left atrium (Use 93621 in conjunction with code 93620)	460.00
93622	with left ventricular pacing and recordings (Use 93622 in conjunction with codes 93620)	460.00
93623	Programmed stimulation and pacing after intravenous drug infusion (Use this code with 93620, 93621, 93622)	50.00
93624	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia	109.00
93631	Intra-operative epicardial and endocardial pacing and mapping to localize the site of tachycardia or zone of slow conduction for surgical correction	224.00
93640	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold at evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement;	200.00
93641	with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator	227.00
	(For subsequent or periodic electronic analysis and/or reprogramming of single or dual chamber pacing cadioverter-defibrillators, see 93642, 93741-93744)	
93642	Electrophysiologic evaluation of cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	219.00

CODE	DESCRIPTION	FEE
93650	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	303.00
93651	Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination	385.00
93652	for treatment of ventricular tachycardia	401.00
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacologial intervention (For physician component, See modifier '26)	100.00
93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to primary procedure) (Use 93662 in conjunction with 93621, 93622, 93651, or 93652, as appropriate) (Do not report 92961 in addition to code 93662)	88.00

OTHER VASCULAR STUDIES

(For radiographic injection procedures, see 36000-36299; for chemotherapy injection procedures, see 96405-96549; for arterial cannulization and recording of direct arterial pressure, see 36620; for vascular cannulization for hemodialysis, see 36800-36821)

93701	Bioimpedance, thoracic; electrical	10.00
93720	Plethysmography, total body; with interpretation and report	25.00
93722	interpretation and report only	10.00
93724	Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)	131.00
93727	Electronic analysis of implantable loop recorder (ILR) system (includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)	20.00
93731	Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming	20.00
93732	with reprogramming	20.00
93733	Electronic analysis of dual chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis	15.00

CODE	DESCRIPTION	FEE
93734	Electronic analysis of single-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming	20.00
93735	with reprogramming	20.00
93736	Electronic analysis of single chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis	15.00
93740	Temperature gradient studies	BR
93741	Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber, or wearable cardioverter-defibrillator system, without reprogramming	20.00
93742	single chamber, or wearable cardioverter-defibrillator system, with reprogramming	20.00
93743	dual chamber, without reprogramming	20.00
93744	dual chamber, with reprogramming	20.00
93770	Determination of venous pressure	5.00
	(For central venous cannulization and pressure measurements, see 36555-36556, 36568-36569, 36580, 36584, 36500)	
93784	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report	60.00
93790	physician review with interpretation and report	42.00
93799	Unlisted cardiovascular service or procedure	BR

NON-INVASIVE VASCULAR DIAGNOSTIC STUDIES

For procedure codes 93875-93990, see Radiology Section General Instructions and General Information and Rules.

Vascular studies include patient care required to perform the studies, supervision of the studies and interpretation of study results with copies for patient records of hard copy output with analysis of all data, including bidirectional vascular flow or imaging when provided. The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reported.

CODE	DESCRIPTION	FEE

Duplex scan (eg, 93880, 93882): Describes an ultrasonic scanning procedure for characterizing the pattern and direction of blood flow in arteries or veins with the production of real time images integrating B-mode two-dimensional vascular structure with spectral and/or color flow Doppler mapping or imaging.

Non-invasive physiologic studies are performed using equipment separate and distinct from the duplex scanner. Codes 93875, 93922, 93923 and 93924, 93965 describe the evaluation of non-imaging physiologic recordings of pressures, Doppler analysis of bi-directional blood flow, plethysmography, and/or oxygen tension measurements appropriate for the anatomic area studied.

CEREBROVASCULAR ARTERIAL STUDIES

93875	Non-invasive physiologic studies of extracraniaL arteries, complete bilateral study, (eg, periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)	40.00
93880	Duplex scan of extracranial arteries; complete bilateral study	108.00
93882	unilateral or limited study	93.00
93886	Transcranial Doppler study of the intracranial arteries; complete study	108.00
93888	limited study	93.00
93890	Transcranial doppler study of the intracranial arteries; vasoreactivity study	68.00
93892	emboli detection without intravenous microbubble injection	73.00
93893	emboli detection with intravenous microbubble injection	71.00

EXTREMITY ARTERIAL STUDIES (INCLUDING DIGITS)

93922	Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)	72.00
93923	Noninvasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (eg, segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with posturalprovocative tests, measurements with reactive hyperemia)	72.00
93924	Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study	72.00
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study	108.00
93926	unilateral or limited study	93.00
93930	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study	108.00
93931	unilateral or limited study	93.00

CODE	DESCRIPTION	FEE
	EXTREMITY VENOUS STUDIES (INCLUDING DIGITS)	
93965	Non-invasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)	108.00
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	108.00
93971	unilateral or limited study	93.00
	VISCERAL AND PENILE VASCULAR STUDIES	
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	67.50
93976	limited study	58.00
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study	67.50
93979	unilateral or limited study	58.00
93980	Duplex scan of arterial inflow and venous outflow of penile vessels; complete study	58.00
93981	unilateral or limited study	42.00
	EXTREMITY ARTERIAL-VENOUS STUDIES	
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	42.00

PULMONARY

Codes 94010-94799 include laboratory procedure(s), interpretation and physician's services (except surgical and anesthesia services as listed in the SURGERY section), unless otherwise stated. If a separate idenitifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported in addition to 94010-94799.

(For bronchoscopy, see 31622-31656)

(For placement of flow directed catheter, see 93503; for central venous catheter placement, see 36555-36556, 36568-36569, 36580, 36584)

(For arterial puncture or catheterization, see 36600, 36620)

(For thoracentesis, see 32000)

(For phlebotomy, therapeutic, see 99195)

(For lung biopsy, needle, see 32405)

(For endotrachael intubation, see 31500)

94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	15.00

CODE	DESCRIPTION	FEE
94014	Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation	15.00
94016	physician review and interpretation only	7.50
94060	Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration	25.00
	(For prolonged exercise test for bronchospasm with pre and post-spirometry use 94620)	
94070	Bronchospasm provovation evaluation, multiple spirometric determinations as in 94010, with administered agents (eg antigen(s), cold air, methacholine)	25.00
94150	Vital capacity, total (separate procedure)	3.00
94200	Maximum breathing capacity, maximal voluntary ventilation	10.00
94240	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method	15.00
94250	Expired gas collection, quantitative, single procedure (separate procedure)	25.00
94260	Thoracic gas volume	15.00
94350	Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time	27.50
94360	Determination of resistance to airflow, oscillatory or plethysmographic methods	15.00
94370	Determination of airway closing volume, single breath tests	15.00
94375	Respiratory flow volume loop	15.00
94620	Pulmonary stress testing; simple (eg, prolonged exercise test for bronchospasm with pre- and post-spirometry)	15.00
94621	complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)	18.00
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device)	3.00
94642	Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment for prophylaxis	3.00
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device (94664 can be reported one time only per day of service)	3.00
94680	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple	25.00
94681	including C02 output, percentage oxygen extracted	25.00
94690	rest, indirect (separate procedure)	7.50
94720	Carbon monoxide diffusing capacity (single breath, steady state)	30.00
94725	Membrane diffusion capacity	15.00
94750	Pulmonary compliance study (plethysmography, volume and pressure measurements)	15.00

CODE	DESCRIPTION	FEE
94770	Carbon dioxide, expired gas determination by infrared analyzer	5.00
94772	Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour continuous recording, infant (includes interpretation and report) (Separate procedure codes for electromyograms, EEG, ECG, and recordings of respiration are excluded when 94772 is reported)	42.00
94799	Unlisted pulmonary service or procedure	BR

ALLERGY AND CLINICAL IMMUNOLOGY

DEFINITIONS:

ALLERGY SENSITIVITY TESTS: the performance and evaluation of selective cutaneous and mucous membrane tests in correlation with the history, physical examination, and other observations of the patient. The number of tests performed should be judicious and dependent upon the history, physical findings, and clinical judgment. All patients should not necessarily receive the same tests nor the same number of sensitivity tests. Maximum fees include observation and interpretation of the tests by a physician. In routine office practice, any of the following items may be billed in addition to the appropriate visit codes.

IMMUNOTHERAPY (Desensitization, Hyposensitization): the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy. Indications for immunotherapy are determined by appropriate diagnostic procedures coordinated with clinical judgment and knowledge of the natural history of allergic diseases.

For professional services for allergen immunotherapy not including provision of allergenic extracts, see appropriate Evaluation and Management code.

ALLERGY TESTING

95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests (**Note**: Must bill with paper claim. Report total number of tests in Field 24E on the claims form. Calculate total amount due as follows: 0.50 for each test up to 60 tests and 0.25 for each test over 60 tests).	0.50
95010	Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests	0.50
95015	Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, specify number of tests	0.75
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, specify number of tests	0.75
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests	0.75
95044	Patch or application test(s) (up to 10 tests) (Specify number of tests)	1.00
95060	Ophthalmic mucous membrane tests	2.00

CODE	DESCRIPTION	FEE
95065	Direct nasal mucous membrane test	2.00

SENSITIVITY TESTING

(Maximum fees include reading of test)

86485	Skin test; candida	5.00
86490	coccidioidomycosis	5.00
86510	histoplasmosis	5.00
86580	tuberculosis, intradermal	5.00
86586	Unlisted antigen, each	5.00

ALLERGEN IMMUNOTHERAPY

Codes 95120-95180 include the professional services necessary for allergen immunotherapy. Office Evaluation and Management codes may be used in addition to allergen immunotherapy if, and only if, other identifiable services are provided at that time.

95120	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single injection	4.50
95125	two or more injections (specify number of injections)	4.50
95130	single stinging insect venom	4.50
95131	two stinging insect venoms	4.50
95132	three stinging insect venoms	4.50
95133	four stinging insect venoms	4.50
95134	five stinging insect venoms	4.50
95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; (to be administered by or under the supervision of another physician) single or multiple antigens, multiple dose vial(s), (specify number of **VIALS)**	5.00
95180	Rapid desensitization procedure, each hour (eg, insulin, penicillin, equine serum)	3.00

NEUROLOGY AND NEUROMUSCULAR PROCEDURES

Neurologic services are typically consultative, and any of the levels of consultation (99241-99255) may be appropriate. In addition, services and skills outlined under Evaluation and Management levels of service appropriate to neurologic illnesses should be coded similarly.

All services listed below (95805-95829) include recording, interpretation by a physician and report. For interpretation only, use modifier -26.

(For ambulatory 24 hour EEG monitoring, see 95950)

(For EEG during nonintracranial surgery, use 95955)

(For WADA activation test, use 95958)

CODE	DESCRIPTION	FEE

SLEEP TESTING

Orders for sleep testing are limited to physician specialists in pulmonology, otolaryngology and neurology. Documentation to support the medical necessity of sleep testing must be maintained in the ordering physician's clinical file. Sleep studies and polysomnography refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six or more hours with physician review, interpretation and report. The studies are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as nasal continuous positive airway pressure (NCPAP). Polysomnography is distinguished from sleep studies by the inclusion of sleep staging which is defined to include a 1-4 lead electroencephalogram (EEG), electro-oculogram (EOG), and a submental electromyogram (EMG). Additional parameters of sleep include: 1) ECG; 2) airflow; 3) ventilation and respiratory effort; 4) gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis; 5) extremity muscle activity, motor activity-movement; 6) extended EEG monitoring; 7) penile tumescence; 8) gastroesophageal reflux; 9) continuous blood pressure monitoring; 10) snoring; 11) body positions; etc.

For a study to be reported as polysomnography, sleep must be recorded and staged.

95805	Multiple sleep latency or maintenance of wakefulness testing,recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	175.00
95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate and oxygen saturation, attended by a technologist	97.00
95808	Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist	109.00
95810	sleep staging with 4 or more additional parameters of sleep, attended by a technologist	109.00
95811	sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist	109.00

ROUTINE ELECTROENCEPHALOGRAPHY (EEG)

EEG codes 95812-95822 include hyperventilation and/or photic stimulation when appropriate. Routine EEG codes 95816-95822 includes 20 to 40 minutes of recording. Extended EEG codes 95812-95813 include reporting times longer than 40 minutes.

95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	35.00
95813	greater than one hour	35.00
95816	Electroencephalogram (EEG); including recording awake and drowsy	35.00
95819	including recording awake and asleep	35.00
95822	recording in coma or sleep only	35.00
95824	cerebral death evaluation only	14.00

(For recording of circadian respiratory patterns of infants, see 94772)

95829	Electrocorticogram at surgery (separate procedure)	90.00

CODE	DESCRIPTION	FEE
95830	Insertion by physician of sphenoidal electrodes for electroencephalographic (EEG) recording (includes tracing, interpretation and report)	40.00

MUSCLE AND RANGE OF MOTION TESTING

95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk	7.50
95832	hand (with or without comparison with normal side)	7.50
95833	total evaluation of body, excluding hands	20.00
95834	total evaluation of body, including hands	20.00
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)	2.50
95852	hand, with or without comparison with normal side	2.50
95857	Tensilon test for myasthenia gravis;	10.00

ELECTROMYOGRAPHY AND NERVE CONDUCTION TESTS

95860	Needle electromyography; one extremity with or without related paraspinal areas	35.00
95861	two extremities with or without related paraspinal areas	70.00
95863	three extremities with or without related paraspinal areas	105.00
95864	four extremities with or without related paraspinal areas	140.00
95865	larynx	30.00
95866	hemidiaphagm	30.00
95867	cranial nerve supplied muscle(s), unilateral	30.00
95868	bilateral	60.00
95869	thoracic paraspinal muscles (excluding T1 or T12)	30.00
95870	limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal,cranial nerve supplied muscles, or sphincters	30.00

(To report a complete study of the extremities, see 95860-95864)
(For needle electromyography of cranial supplied muscles, see 95867, 95868)

95872	Needle electromyography, using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied	30.00

(For anal or urethral sphincter, detrusor, urethra, perineum or abdominal musculature, see 51785, 51792)
(For eye muscles, see 92265)

95875	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)	7.50

CODE	DESCRIPTION	FEE

NERVE CONDUCTION STUDIES

95900	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study	15.00
95903	motor, with F-wave study	15.00
95904	sensory	15.00

(Report 95900, 95903 and/or 95904 only once when multiple sites on the same nerve are stimulated or recorded)

INTRAOPERATIVE NEUROPHYSIOLOGY

95920	Intraoperative neurophysiology testing, per hour	45.00

(Use code 95920 in conjunction with the study performed, 92585, 95822, 95860, 95861, 95867, 95868, 95900, 95904, 95925, 95926, 95927, 95928, 95929, 95930, 95933, 95934, 95936, 95937)
(Code 95920 describes ongoing electrophysiologic testing and monitoring performed during surgical procedures. Code 95920 is reported per hour of service, and includes only the ongoing electrophysiologic monitoring time distinct from performance of specific type(s) of baseline electrophysiologic study(ies) (95860, 95861, 95867, 95868, 95900, 95904, 95933, 95934, 95936, 95937) or interpretation of specific type(s) of baseline electrophysiologic study(ies) (92585, 95822, 95925, 95926, 95927, 95928, 95929, 95930). The time spent performing or interpreting the baseline electrophysiologic study(ies) should not be counted as intraoperative monitoring, but represents separately reportable procedures. Code 95920 should be used once per hour even if multiple electrophysiologic study(ies) are performed. The baseline electrophysiologic study(ies) should be used once per operative session.)

(For electrocorticography, use 95829)
(For intraoperative EEG during nonintracranial surgery, use 95955)
(For intraoperative functional cortical or subcortical mapping, see 95961-95962)
(For intraoperative neurostimulator programming and analysis, see 95970-95975)

AUTONOMIC FUNCTION TESTS

95921	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including two or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio	15.00
95922	vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt	15.00
95923	sudomotor, including one or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential	15.00

CODE	DESCRIPTION	FEE
	EVOKED POTENTIALS AND REFLEX TESTS	
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	30.00
95926	in lower limbs	30.00
95927	in the trunk or head	30.00
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs	50.00
95929	lower limbs	52.00
95930	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash	90.00
95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing	35.00
95934	H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle	15.00
95936	record muscle other than gastrocnemius/soleus muscle	15.00
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method	35.00
	SPECIAL EEG TESTS	
95950	Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours	42.00
95951	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation,(eg, for presurgical localization), each 24 hours	62.50
95953	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG; electroencephalographic(EEG) recording and interpretation, each 24 hours	42.00
95954	Pharmacological or physical activation requiring physician attendance during EEG recording of activation phase (eg, thiopental activation test)	42.00
95955	Electroencephalogram (EEG) during nonintracranial surgery (eg, carotid surgery)	20.00
95956	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry; electroencephalographic (EEG) recording and interpretation, each 24 hour	42.00
95958	Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring	90.00
95961	Functional cortical and subcortical mapping by stimulation, electrodes and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance	60.00
95962	each additional hour of physician attendance (Use 95962 in conjunction with code 95961)	30.00

CODE	DESCRIPTION	FEE

NEUROSTIMULATORS, ANALYSIS-PROGRAMMING

A simple neurostimulator pulse generator/transmitter (95970, 95971) is one capable of affecting 3 or fewer of the following: pulse amplitude, pulse duration, pulse frequency, 8 or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities, does time (stimulation parameters changing in time periods of minutes including dose lockout times), more than 1 clinical feature (eg, rigidity, dyskinesia, tremor). A complex neurostimulator pulse generator/transmitter (95970, 95972, 95973, 95974, 95975) is one capable of affecting more than 3 of the above.

Code 95970 describes subsequent electronic analysis of a previously-implanted simple or complex brain, spinal cord, or peripheral neurostimulator pulse generator system, without reprogramming. Code 95971 describes intraoperative or subsequent electronic analysis of an implanted simple brain, spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator system, with programming. Codes 95972 and 95973 describe intraoperative (at initial insertion/revision) or subsequent electronic analysis of an implanted complex brain, spinal cord or peripheral (except cranial nerve) neurostimulator pulse generator system, with programming. Codes 95974 and 95975 describe intraoperative (at initial insertion/revision) or subsequent electronic analysis of an implanted complex cranial nerve neurostimulator pulse generator system, with programming.

(For insertion of neurostimulator pulse generator, see 61885, 63685, 63688, 64590)

(For revision of removal of neurostimulator pulse generator or receiver, see 61888, 63688, 64595)

(For implantation of neurostimulator electrodes, see 61850-61875, 63650-63655, 64553-64585)

(For revision or removal of neurostimulator electrodes, see 61880, 63660, 64585)

95970	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral(ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming	7.00
95971	simple spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraopoerative or subsequent programming	12.00
95972	complex spinal cord, or peripheral (except cranial) neurostimulator pulse generator/transmitter, with intraopoerative or subsequent programming, first hour	24.00

CODE	DESCRIPTION	FEE
95973	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements);complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraopoerative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to primary procedure) (Use 95973 in conjunction with code 95972)	15.00
95974	complex cranial nerve neurostimulator pulse generator/transmitter, with intraopoerative or subsequent programming, with or without nerve interface testing, first hour	48.00
95975	complex cranial nerve neurostimulator pulse generator/transmitter, with intraopoerative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to primary procedure) (Use 95975 in conjunction with code 95974)	27.00
95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular) (For refilling, maintenance and reprogramming use 62368 only)	15.00
95991	Spinal (intrathecal, epidural) or brain (intraventricular); administered by physician (For analysis and/or reprogramming of implantable infusion pump, see 62367-62368) (For refill and maintenance of implanted infusion pump or reservoir for systemic drug therapy (eg, chemotherapy or insulin, use 96522)	15.00
95999	Unlisted neurological or neuromuscular diagnostic procedure	BR

MOTION ANALYSIS

Codes describe services performed as part of a major therapeutic or diagnosis decision making process. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics and dynamic electromyogrtaphy).

96002	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	45.00
96003	Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle	45.00

CODE	DESCRIPTION	FEE

CENTRAL NERVOUS SYSTEM ASSESSMENTS/TESTS (EG, NEURO-COGNITIVE, MENTAL STATUS, SPEECH TESTING)

The following codes are used to report the services provided during testing of the cognititive function of the central nervous system. The testing of cognitive processes, visual motor responses, and abstractive abilities is accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate material that will be formulated into a report. (When billing for procedure codes 96101 through 96118, the total time billed to New York State Medicaid should reflect the face-to-face contact time with the patient. Reimbursement for all work performed before and after the face-to-face encounter (eg, analysis of tests, reviewing records, etc.) is included in the maximum reimbursable amount for the face-to-face encounter.) More information on time can be found under Medicine Section, Rule #3.

96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, mmpi, rorshach, wais), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	45.00
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	150.00
96111	Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report	150.00
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	150.00
96118	Neuropsychological testing (eg, halstead-reitan neuropsychological battery, wechsler memory scales and wisconsin card sorting test), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	150.00

PHOTODYNAMIC THERAPY

96567	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session (96570, 96571 are to be used in addition to bronchoscopy, endoscopy codes) (To report ocular photodynamic therapy, use 67221)	15.00

CODE	DESCRIPTION	FEE
96570	Photodynamic therapy by endoscopic application of lightto ablate abnormal tissue via activation of photosensitive drug(s), first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)	17.00
96571	each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)	8.50
	(Use 96570, 96571 in conjunction with codes 31641, 43228 as appropriate)	

SPECIAL DERMATOLOGICAL PROCEDURES

Dermatologic services are typically consultative, and any of the levels of consultation (99241-99255) may be appropriate. In addition, services and skills outlined under Evaluation and Management levels of service appropriate to dermatologic illnesses should be coded similarly.

(For intralesional injections, see 11900, 11901)

96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm	44.00
96921	250 sq cm to 500 sq cm	45.00
96922	over 500 sq cm	63.00
96999	Unlisted special dermatological service or procedure	BR

OSTEOPATHIC MANIPULATIVE TREATMENT

Osteopathic manipulative treatment is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

Body regions referred to are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

98925	Osteopathic manipulative treatment (OMT) **(by Osteopath);** one to two body regions involved	1.00
98926	three to four body regions involved	2.00
98927	five to six body regions involved	2.00
98928	seven to eight body regions involved	2.00
98929	nine to ten body regions involved	2.00

SPECIAL SERVICES

MISCELLANEOUS SERVICES

99070	Supplies and materials, provided by the physician over and above those usually included with the office visit or other services rendered (List drugs, trays, supplies, or materials provided)	BR

CODE	DESCRIPTION	FEE
99082	Unusual travel (mileage, per mile, one way, beyond 10 mile radius of point of origin (office or home))	.50

OTHER SPECIAL SERVICES

99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to primary procedure)	200.00

For D.O.S. prior to 7/1/01, see modifier -AF for anesthesia complicated by total body hypothermia and/or pump oxygenator. See Anesthesia Section General Information and Rules.

MODERATE (C0NSCIOUS) SEDATION

Moderate (conscious) sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care.

When providing moderate sedation the following services are included and NOT reported separately:

- Assessment of the patient (not included in intraservice time);
- Establishment of IV access and fluids to maintain patency when performed;
- Administration of agent(s);
- Maintenance of sedation;
- Monitoring of oxygen saturation, heart rate and blood pressure; and
- Recovery (not included in intraservice time)

Intraservice time starts with the administration of the sedation agent(s), requires continous face-to-face attendance and ends at the conclusion of personal contact by the physician providing the sedation.

Do not report 99143-99145 in conjunction with codes that include moderate (conscious) sedation.

Do not report 99148-99150 in conjunction with codes that include moderate (conscious) sedation when performed in a nonfacility setting.

When a second physician other than the healthcare professional performing the diagnostic or therapeutic services provides moderate sedation in the facility setting (eg, hospital, outpatient/ambulatory surgery center, skilled nursing facility) for the procedures that include moderate conscious sedation, the second physician reports 99148-99150. However, for the circumstance in which these services are performed by the second physician in the nonfacility setting (eg, physician office, freestanding imaging center) codes 99148-99150 are NOT reported.

CODE	DESCRIPTION	FEE
99143	Moderate sedation services provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; under 5 years of age, first 30 minutes intra-service time (**15 minutes = 1 unit**)	10.00
99144	age 5 or older, first 30 minutes intra-service time	10.00
99145	each additional 15 minutes intra-service time (List separately in addition to primary service) (Use 99145 in conjunction with 99143, 99144)	5.00
99148	Moderate sedation services provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; under 5 years of age, first 30 minutes intra-service time. **(15 minutes = 1 unit)**	10.00
99149	age 5 years or older, first 30 minutes intra-service time	10.00
99150	each additional 15 minutes intra-service time (List separately in addition tocode for primary service) (Use 99150 in conjunction with 99148, 99149)	5.00
99170	Anogenital examination with colposcopic magnification in childhood for suspected trauma	27.00
99185	Hypothermia; regional	10.00
99186	total body	50.00
99190	Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); each hour	55.00
99191	3/4 hour	41.25
99192	1/2 hour	27.50
99195	Phlebotomy, therapeutic (separate procedure)	10.00
99199	Unlisted special service, procedure	BR

ANESTHESIA SECTION

For moderate conscious sedation, see codes 99143 - 99150.

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

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

GENERAL INFORMATION AND RULES

1. The total values for anesthesia services include pre- and post-operative visits, the administration of the anesthetic and the administration of fluids and/or blood incident to the anesthesia or surgery.

3. When hypothermia and/or a pump oxygenator are employed in conjunction with an anesthetic, see procedure code(s) 99116, 99190, 99191, 99192. Do not report the Anesthesia Basic Value in addition to time when billing code(s) 99116, 99190, 99191, 99192 separately.

   To bill for the anesthesia time, report the appropriate surgery procedure code with modifier -AA. The total time billed should represent the anesthesia time only. Do not include the Anesthesia Basic Value in the calculation of the total anesthesia value.

4. If the general or regional anesthetic is administered by the attending surgeon, the fee will be fifty percent of the ordinarily calculated anesthesia value (see below). Such procedures shall be identified by adding the modifier -47 to the MMIS surgical procedure code. This does not apply to local anesthesia (see Rule #8).

5. In procedures where no value is listed, the basic portion of the calculated value will be the same as listed for comparable procedures. For claiming purposes, the closest comparable surgical procedure code will be used for such procedures.

6. Necessary drugs and materials provided by the anesthesiologist may be charged for separately.

7. Where unusual detention with the patient is essential for the safety and welfare of such patient, the necessary time will be valued on the same basis as indicated below for anesthesia time.

8. No fee will be allowed for local infiltration or digital block anesthesia administered by the operating surgeon.

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

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

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

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

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

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

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

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

CALCULATION OF TOTAL ANESTHESIA VALUES

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

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

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

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

Basic Value + Time Units = TOTAL ANESTHESIA VALUE

CALCULATION OF ANESTHESIA VALUES FOR MULTIPLE/BILATERAL SURGICAL PROCEDURES

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

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

SURGERY SECTION

GENERAL INFORMATION AND RULES

1. **FEES:** Fees or values for office, home and hospital visits, consultations and other medical services are listed in the sections entitled MEDICINE and ANESTHESIA.

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 "Follow-Up Days". Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis. (See modifier -24)

3. **BY REPORT:** When the value of a procedure is indicated as "By Report" (BR), an Operative Report must be submitted with the MMIS claim form for a payment determination to be made. The Operative Report must include the following information:

    a. Diagnosis (post-operative)
    b. Size, location and number of lesion(s) or procedure(s) where appropriate
    c. Major surgical procedure and supplementary procedure(s)
    d. Whenever possible, list the nearest similar procedure by number according to these studies
    e. Estimated follow-up period
    f. Operative time

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

4. **ADDITIONAL SERVICES:** Complications or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional charges on a fee-for-service basis. (See modifiers -24, -25, -79)

5. When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations. (See modifiers -78, -79)

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

7. **MULTIPLE SURGICAL PROCEDURES:**

   a. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total dollar value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s) unless otherwise specified. (For reporting bilateral surgical procedures, see modifier -50).

   b. When an incidental procedure (eg, incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the fee will be that of the major procedure only.

8. **PROCEDURES NOT SPECIFICALLY LISTED:**

   Will be given values comparable to those of the listed procedures of closest similarity. When no similar procedure can be identified, the MMIS procedure codes to be utilized may be found at the end of each section.

9. **SUPPLEMENTAL SKILLS:**

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

10. **SKILLS OF TWO SURGEONS:**

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

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

11. MATERIALS SUPPLIED BY A PHYSICIAN:

Supplies and materials provided by the physician, eg, sterile trays/drugs, **over and above** those usually included with the office visit or other services rendered may be listed separately. List drugs, trays, supplies and materials provided. Identify as **99070.**

Reimbursement for drugs (including vaccines and immunglobulin) furnished by practitioners to their patients is based on the acquisition cost to the practitioner of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the pracitioner will maintain auditable records of the actual itmeized 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 sumbitted to Medicaid for payment, the pracitioner is expected to limit his or her Medicaid claim amount to the actual invoice cost of the drug dosage administered.

12. PRIOR APPROVAL:

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

13. INFORMED CONSENT FOR STERILIZATION:

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

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

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

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

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

14. **RECEIPT OF HYSTERECTOMY INFORMATION:**

Hysterectomies must not be performed for the purpose of sterilization. When hysterectomy procedures are performed and in all cases when procedures identified by MMIS codes 51925, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 56262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58550, 58552, 58553, 58554, 58951, 58953, 58954, 58956, 59135, or 59525 are billed, a properly completed "Hysterectomy Receipt of Information Form" must be attached to the bill for payment. No bill will be processed without a properly completed "Hysterectomy Receipt of Information Form", (DSS-3113).

15. **MMIS MODIFIERS: SURGERY SECTION:**

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

-50 Bilateral Procedure (Surgical): Unless otherwise identified in the listings, bilateral surgical procedures requiring a separate incision that are performed at the same operative session, should be identified by the appropriate five digit code describing the first procedure. To indicate a bilateral surgical procedure was done add modifier -50 to the procedure number. (Reimbursement will not exceed 150% of the maximum State Medical 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 or postoperative management is to be provided in an outpatient department, surgical services may be identified by adding the modifier -54 to the usual procedure number. (Reimbursement will not exceed 80% of the maximum State Medical Fee Schedule amount.)

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

-63 Procedure Performed on Infants Less Than 4 kg: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding modifier –63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20000-69999 code series. Modifier –63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections. (Reimbursement will not exceed 100% of the maximum State Medical 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 State Medical 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 State Medical 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 State Medical 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 State Medical 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 State Medical Fee Schedule amount.)

-99 Multiple Modifiers: Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier -99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

-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 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 State Medical 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 State Medical 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 State Medical Fee Schedule amount. One claim line should be billed.) **(Use modifier –50 when both sides done at same operative session.)**

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

SURGERY SERVICES

GENERAL

10021	Fine needle aspiration; without imaging guidance	60.00		3.0+T
10022	with imaging guidance	72.00		3.0+T

For radiological supervision and interpretation, see 76003, 76360, 76393, 76942)

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

INTERGUMENTARY SYSTEM

SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES

INCISION AND DRAINAGE

10040	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	6.00		3.0+T
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	8.00		3.0+T
10061	complicated or multiple	24.00		3.0+T
10080	Incision and drainage of pilonidal cyst; simple	8.00		3.0+T
10081	complicated	8.00		3.0+T
	(For excision of pilonidal cyst, see 11770-11772)			
10120	Incision and removal of foreign body, subcutaneous tissues; simple	8.00		3.0+T
10121	complicated	16.00		3.0+T
10140	Incision and drainage of hematoma, seroma or fluid collection	8.00		3.0+T
10160	Puncture aspiration of abscess, hematoma, bulla or cyst (If imaging guidance is performed, see 76360,76393, 76942)	4.00		3.0+T
10180	Incision and drainage, complex, postoperative wound infection	16.00		3.0+T
	(For secondary closure of surgical wound, see 12020, 12021, 13160)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
EXCISION - DEBRIDEMENT				
11000	Debridement of extensive eczematous or infected skin; up to 10% of body surface	8.00		3.0+T
11001	each additional 10% of the body surface (List separately in addition to primary procedure)	4.00		
11004	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum	112.00		3.0+T
11005	abdominal wall, with or without fascial closure	156.00		3.0+T
11006	external genitalia, perineum and abdominal wall, with or without fascial closure	156.00		3.0+T
11008	Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection (List separately in addition to primary procedure)	62.00		3.0+T
11010	Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues	94.00	30	3.0+T
11011	skin, subcutaneous tissue, muscle fascia, and muscle	112.00	30	3.0+T
11012	skin, subcutaneous tissue, muscle fascia, muscle, and bone	156.00	30	3.0+T
11040	Debridement; skin, partial thickness	6.00		3.0+T
11041	skin, full thickness	6.00		3.0+T
11042	skin, and subcutaneous tissue	6.00		3.0+T
11043	skin, subcutaneous tissue, and muscle	112.00		3.0+T
11044	skin, subcutaneous tissue, muscle, and bone	156.00		3.0+T
PARING OR CUTTING				
11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion	16.00	30	3.0+T
11056	two to four lesions	20.00	30	3.0+T
11057	more than four lesions	24.00	30	3.0+T
BIOPSY				
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	12.00	15	3.0+T
11101	each separate/additional lesion (List separately in addition to primary procedure)	12.00	15	
	(For biopsy of conjunctiva, see 68100; eyelid, see 67810)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	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	18.00	30	3.0+T
11201	each additional ten lesions	33.00	30	3.0+T
	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	16.00	30	3.0+T
11301	lesion diameter 0.6 to 1.0 cm	20.00	30	3.0+T
11302	lesion diameter 1.1 to 2.0 cm	24.00	30	3.0+T
11303	lesion diameter over 2.0 cm	36.00	30	3.0+T
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	16.00	30	3.0+T
11306	lesion diameter 0.6 to 1.0 cm	20.00	30	3.0+T
11307	lesion diameter 1.1 to 2.0 cm	24.00	30	3.0+T
11308	lesion diameter over 2.0 cm	36.00	30	3.0+T
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	16.00	30	3.0+T
11311	lesion diameter 0.6 to 1.0 cm	20.00	30	3.0+T
11312	lesion diameter 1.1 to 2.0 cm	24.00	30	3.0+T
11313	lesion diameter over 2.0 cm	36.00	30	3.0+T
	EXCISION – BENIGN LESIONS			
	Excision (including simple closure) of benign lesions of skin (eg, neoplasm, cicatricial, fibrous, inflammatory, congenital, cystic lesions), includes local anesthesia. See appropriate size and area below. For shave removal, see 11300 et seq., and for electrosurgical and other methods, see 17000 et seq.			
	Excision is defined as full-thickness (through the dermis) removal of a lesion, including margins, and includes simple (non-layered) closure when performed. Report separately each benign lesion excised. Code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required equals the excised diameter). The margins refer to the most narrow margin required to adequately excise the lesion, based on the physician's judgement. The measurement of lesion plus margin is made prior to excision. The excised diameter is the same whether the surgical defect is repaired in a linear fashion, or reconstructed (eg, with a skin graft).			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	The closure of defects created by incision, excision, or trauma may require intermediate or complex closure. Repair by intermediate or complex closure should be reported separately. For excision of benign lesions requiring more than simple closure, ie, requiring intermediate or complex closure, report 11400-11466 in addition to appropriate intermediate (12031-12057) or complex closure (13100-13153) codes. For reconstructive closure, see 11400-14300, 15000-15261, 15570-15770. For definition of intermediate or complex closure, see Integumentary System, Repair (Closure).			
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	16.00	30	3.0+T
11401	excised diameter 0.6 to 1.0 cm	20.00	30	3.0+T
11402	excised diameter 1.1 to 2.0 cm	24.00	30	3.0+T
11403	excised diameter 2.1 to 3.0 cm	36.00	30	3.0+T
11404	excised diameter 3.1 to 4.0 cm	36.00	30	3.0+T
11406	excised diameter over 4.0 cm	36.00	30	3.0+T
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	16.00	30	3.0+T
11421	excised diameter 0.6 to 1.0 cm	20.00	30	3.0+T
11422	excised diameter 1.1 to 2.0 cm	24.00	30	3.0+T
11423	excised diameter 2.1 to 3.0 cm	36.00	30	3.0+T
11424	excised diameter 3.1 to 4.0 cm	36.00	30	3.0+T
11426	excised diameter over 4.0 cm	36.00	30	3.0+T
11440	Excision, other benign lesion including margins, (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less	16.00	30	3.0+T
11441	excised diameter 0.6 to 1.0 cm	20.00	30	3.0+T
11442	excised diameter 1.1 to 2.0 cm	24.00	30	3.0+T
11443	excised diameter 2.1 to 3.0 cm	36.00	30	3.0+T
11444	excised diameter 3.1 to 4.0 cm	36.00	30	3.0+T
11446	excised diameter over 4.0 cm	36.00	30	3.0+T
	(For eyelids involving more than skin, see also 67800 et seq)			
11450	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair	8.00		3.0+T
11451	with complex repair	12.00		3.0+T
11462	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair	8.00		3.0+T
11463	with complex repair	12.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
11470	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal or umbilical; with simple or intermediate repair	8.00		3.0+T
11471	with complex repair	12.00		3.0+T

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 14000-14300, 15000-15261, 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, asappropriate.

11600	Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 0.5 cm or less	24.00	90	3.0+T
11601	excised diameter 0.6 to 1.0 cm	32.00	90	3.0+T
11602	excised diameter 1.1 to 2.0 cm	40.00	90	3.0+T
11603	excised diameter 2.1 to 3.0 cm	50.00	90	3.0+T
11604	excised diameter 3.1 to 4.0 cm	60.00	90	3.0+T
11606	excised diameter over 4.0 cm	70.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
11620	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	40.00	90	3.0+T
11621	excised diameter 0.6 to 1.0 cm	60.00	90	3.0+T
11622	excised diameter 1.1 to 2.0 cm	80.00	90	3.0+T
11623	excised diameter 2.1 to 3.0 cm	90.00	90	3.0+T
11624	excised diameter 3.1 to 4.0 cm	100.00	90	3.0+T
11626	excised diameter over 4.0 cm	110.00	90	3.0+T
11640	Excision, malignant lesion includingmargins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less	60.00	90	3.0+T
11641	excised diameter 0.6 to 1.0 cm	80.00	90	3.0+T
11642	excised diameter 1.1 to 2.0 cm	100.00	90	3.0+T
11643	excised diameter 2.1 to 3.0 cm	110.00	90	3.0+T
11644	excised diameter 3.1 to 4.0 cm	120.00	90	3.0+T
11646	excised diameter over 4.0 cm	130.00	90	3.0+T
	(For eyelids involving more than skin, see also 67800 et seq)			

NAILS

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

11720	Debridement of nail(s) by any method(s); one to five	8.00		3.0+T
11721	six or more	12.00		3.0+T
11730	Avulsion of nail plate, partial orcomplete, simple; single	8.00		3.0+T
11732	each additional nail plate	2.00		
11740	Evacuation of subungual hematoma	4.00		3.0+T
11750	Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;	40.00	30	3.0+T
11752	with amputation of tuft of distal phalanx	80.00	45	3.0+T
	(For skin graft, if used, see 15050)			
11755	Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (seperate procedure)	12.00		
11760	Repair of nail bed	30.00	30	3.0+T
11762	Reconstruction of nail bed with graft	36.00	30	3.0+T
11765	Wedge excision of skin of nail fold (eg, for ingrown toenail)	20.00	30	3.0+T
	(For incision of pilonidal cyst, see 10080-81)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	PILONIDAL CYST			
11770	Excision of pilonidal cyst or sinus; simple	120.00	60	3.0+T
11771	extensive	120.00	60	3.0+T
11772	complicated	120.00	60	3.0+T
	INTRODUCTION			
11900	Injection, intralesional; up to and including seven lesions	8.00		3.0+T
11901	more than seven lesions	12.00		3.0+T
	(11900, 11901 are not to be used for preoperative local anesthetic injection) (For veins, see 36470, 36471, for intralesional chemotherapy administration, see 96405, 96406)			
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	40.00		3.0+T
11921	6.1 to 20.0 sq cm	50.00		3.0+T
11922	each additional 20.0 sq cm (List separately in addition to primary procedure)	BR		
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	8.00		3.0+T
11951	1.1 to 5 cc	12.00		3.0+T
11952	5.1 to 10 cc	14.00		3.0+T
11954	over 10 cc	15.00		3.0+T
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	50.00		3.0+T
	(For breast reconstruction with tissue expander(s), see 19357)			
11970	Replacement of tissue expander with permanent prosthesis	50.00		3.0+T
11971	Removal of tissue expander(s) without insertion of prosthesis	50.00		3.0+T
11975	Insertion, implantable contraceptive capsules	81.00		
11976	Removal, implantable contraceptive capsules	57.00		
11977	Removal with reinsertion, implantable contraceptive capsules	109.50		
J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies			
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	81.00		
11981	Insertion, non-biodegradable drug delivery implant	81.00		
11982	Removal, non-biodegradable drug delivery implant	57.00		

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
11983	Removal with reinsertion, non-biodegradable drug delivery implant	109.50		

REPAIR (CLOSURE)

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

DEFINITIONS:

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

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

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

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

Instructions for listing services at time of wound repair:

1. The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular or stellate.

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

3. Decontamination and/or debridement: Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure. (For extensive debridement of soft tissue and/or bone, see 11040-11044)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

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 enlargment, extension of dissection (to determine penetration), debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s), of the subcutaneous tissue, muscle, fascia, and/or muscle, not requiring thoracotomy or laparotomy, use codes 20100-20103, as appropriate.

REPAIR-SIMPLE (Sum of length of repairs for each group of anatomic sites)

12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	8.00		3.0+T
12002	2.6 cm to 7.5 cm	10.00		3.0+T
12004	7.6 cm to.12.5 cm	12.00		3.0+T
12005	12.6 cm to 20.0 cm	14.00		3.0+T
12006	20.1 cm to 30.0 cm	16.00		3.0+T
12007	over 30.0 cm	25.00		3.0+T
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	5.50		3.0+T
12013	2.6 cm to 5.0 cm	8.00		3.0+T
12014	5.1 cm to 7.5 cm	12.00		3.0+T
12015	7.6 cm to 12.5 cm	20.00		3.0+T
12016	12.6 cm to 20.0 cm	32.00		3.0+T
12017	20.1 cm to 30.0 cm	48.00		3.0+T
12018	over 30.0 cm	66.00		3.0+T
12020	Treatment of superficial wound dehiscence; simple closure	80.00		3.0+T

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

REPAIR-INTERMEDIATE (Sum of length of repairs.)

12031	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less	36.00	30	3.0+T
12032	2.6 cm to 7.5 cm	77.00	30	3.0+T
12034	7.6 cm to.12.5 cm	90.00	30	3.0+T
12035	12.6 cm to 20.0 cm	100.00	30	3.0+T
12036	20.1 cm to 30.0 cm	110.00	30	3.0+T
12037	over 30.0 cm	120.00	30	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
12041	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less	32.00	30	3.0+T
12042	2.6 cm to 7.5 cm	120.00	30	3.0+T
12044	7.6 cm to.12.5 cm	130.00	30	3.0+T
12045	12.6 cm to 20.0 cm	140.00	30	3.0+T
12046	20.1 cm to 30.0 cm	150.00	30	3.0+T
12047	over 30.0 cm	160.00	30	3.0+T
12051	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	68.00	30	3.0+T
12052	2.6 cm to 5.0 cm	160.00	30	3.0+T
12053	5.1 cm to 7.5 cm	160.00	30	3.0+T
12054	7.6 cm to 12.5 cm	170.00	30	3.0+T
12055	12.6 cm to 20.0 cm	180.00	30	3.0+T
12056	20.1 cm to 30.0 cm	190.00	30	3.0+T
12057	over 30.0 cm	200.00	30	3.0+T

REPAIR-COMPLEX (Sum of length of repairs for each group of anatomic sites)

(Reconstructive procedures, complicated wound closure)

(Fr full thickness repair of lip or eyelid, see respective anatomical subsections.)

(For repairs of 1.0 cm or less, see Simple or Intermediate Repair, except as listed in 13150)

13100	Repair, complex, trunk; 1.1 cm to 2.5 cm	28.00	30	3.0+T
13101	2.6 cm to 7.5 cm	60.00	30	3.0+T
13102	each additional 5 cm or less (List separately in addition to primary procedure)	21.00		
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm	40.00	30	3.0+T
13121	2.6 cm to 7.5 cm	88.00	30	3.0+T
13122	each additional 5 cm or less (List separately in addition to primary procedure)	24.00	30	3.0+T
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	56.00	30	3.0+T
13132	2.6 cm to 7.5cm	120.00	30	3.0+T
13133	each additional 5 cm or less (List separately in addition to primary procedure)	37.00	30	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less (see also 40650-40654, 67961-67975)	40.00	30	3.0+T
13151	1.1 cm to 2.5 cm	68.00	30	3.0+T
13152	2.6 cm to 7.5 cm	160.00	30	3.0+T
13153	each additional 5 cm or less (List separately in addition to primary procedure)	40.00		
13160	Secondary closure of surgical wound or dehiscence, extensive or complicated	180.00	30	3.0+T

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

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

14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less	149.00	30	3.0+T
14001	defect 10.1 sq cm to 30.0 sq cm	194.00	30	3.0+T
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm. Or less	163.00	30	3.0+T
14021	defect 10.1 sq cm to 30.0 sq cm	217.00	30	3.0+T
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	181.00	30	3.0+T
14041	defect 10.1 sq cm to 30.0 sq cm	240.00	30	3.0+T
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	193.00	30	3.0+T
14061	defect 10.1 sq cm to 30.0 sq cm	260.00	30	3.0+T
14300	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area	248.00	30	3.0+T
14350	Filleted finger or toe flap, including preparation of recipient site	184.00	30	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

SKIN REPLACEMENT SURGERY AND SKIN SUBSTITUTES

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

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

Use 15000, 15001 for initial wound recipient site preparation.

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

The repair of donor site graft or local flaps is considered an additional separate procedure.

Codes 15000 and 15001 describe burn and wound preparation or incisional or excisional release of scar contracture resulting in an open wound requiring a skin graft. Codes 15100-15431 describe the application of skin replacements and skin substitutes. The following definition should be applied to those codes that reference “100 sq cm or one percent of body area of infants and children” when determining the involvement of body size: The measurement of 100 sq cm is applicable to adults and children age 10 and over, percentages of body surface area apply to infants and children under the age of 10.

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

(For microvascular flaps, see 15756-15758)

15000	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; first 100 sq cm or one percent of body area of infants and children	54.00	3.0+T

(For appropriate skin grafts or replacements, see 15050-15261, 15330-15336. List the graft or replacement separately by its procedure number when the graft, immediate or delayed, is applied)

15001	each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to primary procedure)	18.00	

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	AUTOGRAFT/TISSUE CULTURED AUTOGRAFT			
15040	Harvest of skin for tissue cultured skin autograft, 100 sq cm or less	43.00		3.0+T
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	20.00	45	3.0+T
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)	145.00	45	3.0+T
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)	39.00	45	
15110	Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	136.00	90	3.0+T
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)	23.00		
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	128.00	90	3.0+T
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)	30.00		
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)	173.00	45	3.0+T
15121	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	66.00	45	
	(For eyelids, see also 67961 et seq)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
15130	Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	113.00	90	3.0+T
15131	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	19.00		
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	137.00	90	3.0+T
15136	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	18.00		
15150	Tissue cultured epidermal autograft, trunk, arms, legs; first 25 sq cm or less	113.00	90	3.0+T
15151	additional 1 sq cm to 75 sq cm (List separately in addition to primary procedure)	25.00		
15152	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	30.00		
15155	Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less	113.00	90	3.0+T
15156	additional 1 sq cm to 75 sq cm (List separately in addition to primary procedure)	32.00		
15157	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	35.00		
	ACELLULAR DERMAL REPLACEMENT			
15170	Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	59.00	90	3.0+T
15171	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	17.00		

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
15175	Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	84.00	90	3.0+T
15176	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	26.00		
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less	132.00	45	3.0+T
15201	each additional 20 sq cm	42.00	45	
15220	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less	120.00	45	3.0+T
15221	each additional 20 sq cm	40.00	45	
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	166.00	45	3.0+T
15241	each additional 20 sq cm	55.00	45	
	(For finger tip graft, see 15050) (For repair of syndactyly, fingers, see 26560-26562)			
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	194.00	45	3.0+T
15261	each additional 20 sq cm	66.00	45	
	(For eyelids, see also 67961 et seq)			

ALLOGRAFT/TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE

15300	Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	49.00	90	3.0+T
15301	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	24.00		

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
15320	Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	57.00	90	3.0+T
15321	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	35.00		
15330	Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	49.00	90	3.0+T
15331	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	23.00		
15335	Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	55.00	90	3.0+T
15336	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	34.00		
15340	Tissue cultured allogeneic skin substitute; first 25 sq cm or less	52.00	10	3.0+T
15341	each additional 25 sq cm	17.00		
15360	Tissue cultured allogeneic dermal substitute; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	56.00	90	3.0+T
15361	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	27.00		
15365	Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	59.00	90	3.0+T
15366	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	34.00		

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	XENOGRAFT			
15400	Xenograft, skin (dermal), for temporary wound closure; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children	66.00	45	3.0+T
15401	each additional 100 sq cm or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	24.00		
15420	Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	77.00	90	3.0+T
15421	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	24.00		
15430	Acellular xenograft implant; first 100 sq cm or less, or one percent of body area of infants and children	104.00	90	3.0+T
15431	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to primary procedure)	24.00		

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	141.00	90	3.0+T
15572	scalp, arms, or legs	136.00	90	3.0+T
15574	forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet	134.00	90	3.0+T
15576	eyelids, nose, ears, lips, or intraoral	86.00	90	3.0+T
	(For major debridement or excisional preparation of recipient area at the time of attachment of pedicle flap, see 15570-15576)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
15600	Delay of flap or sectioning of flap (division and inset); at trunk	60.00	45	3.0+T
15610	at scalp, arms, or legs	88.00	45	3.0+T
15620	at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet	120.00	45	3.0+T
15630	at eyelids, nose, ears, or lips	148.00	45	3.0+T
15650	Transfer, intermediate, of any pedicle flap (eg, abdomen to wrist, Walking tube), any location	160.00	45	3.0+T
	(For eyelids, nose, ears or lips, see also specific anatomic section) (For revision, defatting or rearranging of transferred pedicle flap or skin graft, see 13100-14300)			
15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, massetermuscle, sternocleidomastoid, levator scapulae)	340.00	45	3.0+T
15734	trunk	350.00	45	3.0+T
15736	upper extremity	320.00	45	3.0+T
15738	lower extremity	340.00	45	3.0+T

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	280.00	45	3.0+T
15750	neurovascular pedicle	280.00	45	3.0+T
15756	Free muscle or myocutaneous flap with microvascular anastomosis (Do not report code 69990 in addition to code 15756)	700.00	45	3.0+T
15757	Free skin flap with microvascular anastomosis	700.00	45	3.0+T
15758	Free fascial flap with microvascular anastomosis	700.00	45	3.0+T
15760	Graft; composite (full thickness of external ear or nasal ala), including primary closure, donor area	100.00	45	3.0+T
15770	derma-fat-fascia	180.00	60	3.0+T
15775	Punch graft for hair transplant; 1 to 15 punch grafts	BR		3.0+T
15776	more than 15 punch grafts	BR		3.0+T
	(For strip transplant, use 15220)			

OTHER PROCEDURES

15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	240.00	90	3.0+T
15781	segmental, face	55.00	60	3.0+T
15782	regional, other than face	55.00	60	3.0+T
15783	superficial, any site, (eg, tattoo removal)	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
15786	Abrasion; single lesion (eg, keratosis, scar)	8.00		3.0+T
15787	each additional four lesions or less (List separately in addition to primary procedure)	8.00		
15788	Chemical peel, facial; epidermal	49.00		3.0+T
15789	dermal	60.00		3.0+T
15792	Chemical peel, nonfacial; epidermal	32.00		3.0+T
15793	dermal	40.00		3.0+T
15819	Cervicoplasty	193.00	30	3.0+T
15820	Blepharoplasty, lower eyelid;	127.00		3.0+T
15821	with extensive herniated fat pad	146.00		3.0+T
15822	Blepharoplasty, upper eyelid;	123.00		3.0+T
15823	with excessive skin weighting down lid	163.00		3.0+T
15824	Rhytidectomy; forehead	200.00	30	3.0+T
15825	neck with platysmal tightening (platysmal flap, P-flap)	240.00	30	3.0+T
15826	glabellar frown lines	160.00	30	3.0+T
15828	cheek, chin, and neck	600.00	45	3.0+T
15829	superficial musculoaponeurotic system (SMAS) flap	BR	45	3.0+T
15831	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty)	256.00		3.0+T
15832	thigh	224.00		3.0+T
15833	leg	189.00		3.0+T
15834	hip	202.00		3.0+T
15835	buttock	209.00		3.0+T
15836	arm	171.00		3.0+T
15837	forearm or hand	162.00		3.0+T
15838	submental fat pad	146.00		3.0+T
15839	other area	129.00		3.0+T
15840	Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)	400.00	100	4.0+T
15841	free muscle graft (including obtaining graft)	447.00	100	4.0+T
15842	free muscle flap by microsurgical technique	447.00	100	4.0+T
15845	regional muscle transfer	480.00	120	4.0+T

(For intravenous fluorescein examination of blood flow in graft or flap, see 15860)

(For nerve transfers, decompression, or repair, see 64831-64876, 64905, 64907, 69720, 69725, 69740, 69745, 69955)

15850	Removal of sutures under anesthesia (other than local), same surgeon (See Rule 4)	13.00		3.0+T
15851	Removal of sutures under anesthesia (other than local), other surgeon	13.00		3.0+T
15852	Dressing change (for other than burns) under anesthesia (other than local) (See Rule 4)	15.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
15860	Intravenous injection of agent (eg, fluorescein) to test vascular flow in flap or graft	39.00		3.0+T
15876	Suction assisted lipectomy; head and neck	BR		3.0+T
15877	trunk			3.0+T
15878	upper extremity	BR		3.0+T
15879	lower extremity	BR		3.0+T

PRESSURE ULCERS (DECUBITIS ULCERS)

(To identify muscle or myocutaneous flap closure, use code number for specific flap)

15920	Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture	119.00		3.0+T
15922	with flap closure	178.00		3.0+T
15931	Excision, sacral pressure ulcer, with primary suture;	126.00		3.0+T
15933	with ostectomy	196.00		3.0+T
15934	Excision, sacral pressure ulcer, withskin flap closure	221.00		3.0+T
15935	with ostectomy	289.00		3.0+T
15936	Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;	257.00		3.0+T
15937	with ostectomy	316.00		3.0+T
15940	Excision, ischial pressure ulcer, with primary suture;	136.00		3.0+T
15941	with ostectomy	202.00		3.0+T
15944	Excision, ischial pressure ulcer, with skin flap closure;	231.00		3.0+T
15945	with ostectomy	267.00		3.0+T
15946	Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin graft closure	431.00		3.0+T
15950	Excision, trochanteric pressure ulcer, with primary suture;	113.00		3.0+T
15951	with ostectomy	204.00		3.0+T
15952	Excision, trochanteric pressure ulcer, with skin flap closure;	203.00		3.0+T
15953	with ostectomy	243.00		3.0+T
15956	Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;	375.00		3.0+T
15958	with ostectomy	385.00		
15999	Unlisted procedure, excision pressure ulcer	BR		

(For free skin graft to close ulcer or donor site, see 15000 et seq)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

BURNS, LOCAL TREATMENT

Procedures 16000-16036 refer to local treatment of burned surface only.

List percentage of body surface involved and depth of burn.

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

(For skin graft, see 15100-15650)

16000	Initial treatment, first degree burn, when no more than local treatment is required	6.00		
16020	Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)	8.00		3.0+T
16025	medium (eg, whole face or whole extremity or 5% to 10% total body surface area)	12.00		
16030	large (eg, more than one extremity, or greater than 10% total body surface area)	16.00		
16035	Escharotomy; initial incision	73.00		3.0+T
16036	each additional incision (List separately in addition to primary procedure) (Use 16036 in conjunction with code 16035)	25.00		

(For debridement, curettement of burn wound, see 16010-16030)

DESTRUCTION

Destruction means the ablation of benign, pre-malignant or malignant tissues by any method, with or without curettement, including local anesthesia, and not usually requiring closure. Any method includes electrocautery, electrodesiccation, cryosurgery, laser and chemical treatment. Lesions include condylomata, papillomata, molluscum contagiosum, herpetic lesions, warts (ie, common, plantar, flat), milia, or other benign, pre-malignant (eg, actinic keratoses), or malignant lesions.

(For sharp removal of skin tags and fibrocutaneous lesions, see codes 11200, 11201)

(For destruction of lesion(s) in specific anatomic sites; see 40820, 46900-46917, 46924, 54050-54057, 54065, 56501, 56515, 57061, 57065, 67850, 68135)

(For paring or cutting of benign hyperkeratonic lesions (eg, corns or calluses), see 11055 – 11057)

(For cryotherapy of acne, use 17340)

(For initiation or follow-up care of topical chemotherpay (eg, 5-FU or similar agents), see appropriate office visits)

(For shaving of epidermal or dermal lesions, see 11300-11313)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	DESTRUCTION, BENIGN OR PREMALIGNANT LESIONS			
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (e.g., actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion	18.00	10	3.0+T
17003	second through 14 lesions, each	4.00		
17004	15 or more lesions (Do not report in addition to 17000 – 17003)	80.00	10	
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	75.00	90	3.0+T
17107	10.0 - 50.0 sq cm	150.00	90	3.0+T
17108	over 50.0 sq cm	200.00	90	3.0+T
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgicaL curettement), flat warts, molluscum contagiosum, or milia; up to 14 lesions	8.00	10	3.0+T
17111	15 or more lesions	11.00	10	3.0+T
	(For common or plantar warts, see 17000, 17003, 17004) (Retreatment same as office evaluation and management services) (For excision of fibrocutaneous tags, see 11200, 11201)			
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)	8.00		3.0+T
	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	24.00	90	3.0+T
17261	lesion diameter 0.6 to 1.0 cm	32.00	90	3.0+T
17262	lesion diameter 1.1 to 2.0 cm	40.00	90	3.0+T
17263	lesion diameter 2.1 to 3.0 cm	50.00	90	3.0+T
17264	lesion diameter 3.1 to 4.0 cm	BR		3.0+T
17266	lesion diameter over 4.0 cm	BR		3.0+T
17270	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	40.00	90	3.0+T
17271	lesion diameter 0.6 to 1.0 cm	60.00	90	3.0+T
17272	lesion diameter 1.1 to 2.0 cm	80.00	90	3.0+T
17273	lesion diameter 2.1 to 3.0 cm	100.00	90	3.0+T
17274	lesion diameter 3.1 to 4.0 cm	120.00	90	3.0+T
17276	lesion diameter over 4.0 cm	140.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
17280	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	60.00	90	3.0+T
17281	lesion diameter 0.6 to 1.0 cm	80.00	90	3.0+T
17282	lesion diameter 1.1 to 2.0 cm	100.00	90	3.0+T
17283	lesion diameter 2.1 to 3.0 cm	BR		3.0+T
17284	lesion diameter 3.1 to 4.0 cm	BR		3.0+T
17286	lesion diameter over 4.0 cm	BR		3.0+T
	MOHS' MICROGRAPHIC SURGERY			
17304	Chemosurgery (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 complete histopathologic preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); first stage, fresh tissue technique, up to 5 specimens	80.00	30	3.0+T
17305	second stage, fixed or fresh tissue, up to 5 specimens	20.00	30	3.0+T
17306	third stage, fixed or fresh tissue, up to 5 specimens	20.00	30	3.0+T
17307	additional stage(s), up to 5 specimens, each stage	4.00	30	3.0+T
17310	each additional specimen, after the first 5 specimens, fixed or fresh tissue,any stage (List separately in addition to primary procedure) (Use 17310 in conjunction with codes 17304-17307)	BR	30	3.0+T
	(For initiation or follow-up care of topical chemotherapy (eg, 5-FU or similar agents), see appropriate office evaluation and management service)			
	OTHER PROCEDURES			
17340	Cryotherapy (C02 slush, liquid N2)for acne	6.00		3.0+T
17360	Chemical exfoliation for acne(eg, acne paste, acid)	8.00		3.0+T
17380	Electrolysis epilation, each 1/2 hour	12.00		3.0+T
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	BR		3.0+T
	BREAST			
	(To report bilateral procedures, use modifier -50)			
	(For needle localization of breast nodules, see 76096)			
	INCISION			
19000	Puncture aspiration of cyst breast;	8.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
19001	Puncture aspiration of cyst breast;each additional cyst (List separately in addition to primary procedure)	4.00		
	(If imaging guidance is performed, see 76095, 76096, 76393, 76942)			
19020	Mastotomy with exploration or drainage of abscess, deep	40.00	14	3.0+T
19030	Injection procedure only for mammary ductogram or galactogram	20.00		
	(For radiological supervision and interpretation, see 76086, 76088)			
EXCISION				
19100	Biopsy of breast; percutaneous, needle core, not using needle guidance (separate procedure)	60.00		3.0+T
	(For fine needle aspiration, use 10021) (For image guided breast biopsy, see 10022, 19102, 19103) (For radiologic guidance performed in conjunction with breast biopsy, see 76095, 76360, 76393, 76942)			
19101	open, incisional	122.00	10	3.0+T
19102	percutaneous, needle code, using imaging guidance	72.00		3.0+T
	(For placement of percutaneous localization clip, use 19295)			
19103	percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	143.00		3.0+T
	(For imaging guidance performed in conjunction with 19102, 19103, see 76095, 76096, 76360, 76393, 76942) (For placement of percutaneous localization clip, use 19295)			
19110	Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct	120.00		3.0+T
19112	Excision of lactiferous duct fistula	100.00		3.0+T
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19140), open, male or female, one or more lesions	182.00	30	3.0+T
19125	Excision of breast lesion identified by pre-operative placement of radiological marker, open; single lesion	102.00	30	3.0+T
19126	each additional lesion separately identified by a preoperative radiological maker (Use 19126 in conjunction with code 19125)	51.00		
19140	Mastectomy for gynecomastia	60.00	30	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
19160	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	60.00	30	3.0+T
19162	with axillary lymphadenectomy	220.00	60	3.0+T
19180	Mastectomy, simple, complete	120.00	45	3.0+T
	(For immediate or delayed insertion of implant, use 19340 or 19342) (For gynecomastia, see 19140)			
19182	Mastectomy, subcutaneous	160.00	60	3.0+T
19200	Mastectomy, radical, including pectoral muscles, axillary lymph nodes	280.00	60	3.0+T
19220	Mastectomy, radical, including pectoralmuscles, axillary and internal mammary lymph nodes (Urban type operation)	280.00	60	3.0+T
19240	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	240.00	60	3.0+T
19260	Excision of chest wall tumor including ribs	280.00	60	9.0+T
19271	Excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy	400.00	60	9.0+T
19272	with mediastinal lymphadenectomy	560.00	60	9.0+T
INTRODUCTION				
19290	Preoperative placement of needle localization wire, breast;	40.00		3.0+T
19291	each additional lesion	20.00		3.0+T
	(For radiological supervision and interpretation, see 76095, 76096, 76942)			
19295	Image guided placement, metallic localization clip, percutaneous, during breast biopsy (List separately in addition to primary procedure) (Use 19295 in conjunction with code 19102, 19103)	28.00		
19296	Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy	BR		3.0+T
19297	concurrent with partial mastectomy (List separately in addition to primary procedure)	27.00		3.0+T
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	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

REPAIR AND/OR RECONSTRUCTION

(To report bilateral procedures, add modifier -50; to identify muscle, myocutaneous or free flap closure, use also code number for specific flap)

19316	Mastopexy (unilateral)	400.00	90	3.0+T
19318	Reduction mammaplasty (unilateral)	400.00	90	3.0+T
19324	Mammaplasty, augmentation; without prosthetic implant	300.00	90	3.0+T
19325	with prosthetic implant	300.00	90	3.0+T
19328	Removal of intact mammary implant	100.00	45	3.0+T
19330	Removal of implant material	120.00	45	3.0+T
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	300.00	90	3.0+T
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	300.00	90	3.0+T
	(For preparation of custom breast implant, see 19396)			
19350	Nipple/areola reconstruction	180.00	30	3.0+T
19355	Correction of inverted nipples	150.00	30	3.0+T
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	360.00	90	3.0+T
19361	Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant	460.00	90	3.0+T
19364	Breast reconstruction with free flap	525.00	90	3.0+T
19366	Breast reconstruction with other technique	430.00	90	3.0+T
	(For insertion of prosthesis, use also 19340 or 19342)			
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;	525.00	90	3.0+T
19368	with microvascular anastomosis (supercharging)	600.00	90	3.0+T
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site	570.00	90	3.0+T
	(For insertion of prosthesis, use also 19340 or 19342)			
19370	Open periprosthetic capsulotomy, breast	160.00	90	3.0+T
19371	Periprosthetic capsulectomy, breast	200.00	90	3.0+T
19380	Revision of reconstructed breast	200.00	90	3.0+T
19396	Preparation of moulage for custom breast implant	BR	90	3.0+T
19499	Unlisted procedure, breast	BR	90	3.0+T

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. Treatment is used when a fracture is stabilized by an intramedullary implant, as this procedure may be performed either "open" or "closed". In "closed" intramedullary nailing, the fracture fragments are not visualized, but an intramedullay nail is inserted across the fracture site, with the aid of x-ray imaging. As such, a closed nailing procedure is neither open (where the fracture site is visualized and reduced under direct vision) nor is it strictly closed (because the fracture hematoma can communicate with the outside environment).

CLOSED TREATMENT "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: without manipulation, with manipulation or with or without traction.

OPEN TREATMENT "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 "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.

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

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

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

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."

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

GENERAL

INCISION

20000	Incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial	8.00		3.0+T
20005	deep or complicated	40.00	15	3.0+T

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	168.00	15	3.0+T
20101	chest	53.00	15	3.0+T
20102	abdomen/flank/back	65.00	15	3.0+T
20103	extremity	88.00	15	3.0+T

EXCISION

20150	Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision	60.00	180	5.0+T
20200	Biopsy, muscle; superficial	20.00	15	3.0+T
20205	deep	40.00	15	3.0+T
20206	Biopsy, muscle, percutaneous needle	20.00	7	3.0+T

(For fine needle aspiration, use 10021, 10022)
(If imaging guidance is performed, see 76360, 76393, 76942)
(For excision of muscle tumor, deep, see specific anatomic section)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
20220	Biopsy, bone, trocar or needle; superficial (eg, ilium, sternum, spinous process, ribs)	12.00	7	3.0+T
20225	deep (eg, vertebral body, femur)	40.00	7	4.0+T
	(For bone marrow biopsy, use 38221) (For radiological supervision and interpretation, see 76003, 76360, 76393)			
20240	Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur)	40.00	15	3.0+T
20245	deep (eg, humerus, ischium, femur)	80.00	15	3.0+T
20250	Biopsy, vertebral body, open; thoracic	160.00	45	3.0+T
20251	lumbar or cervical	160.00	45	3.0+T
	(For sequestrectomy, osteomyelitis or drainage of bone abscess, see. specific anatomic section)			
	INTRODUCTION OR REMOVAL			
	(For injection procedure for arthrography, see specific anatomic section)			
20500	Injection of sinus tract; therapeutic (separate procedure)	5.00		3.0+T
20501	diagnostic (sinogram)	5.00		3.0+T
	(For radiological supervision and interpretation, see 76080)			
20520	Removal of foreign body in muscle, or tendon sheath, simple	20.00		3.0+T
20525	deep or complicated	40.00		3.0+T
20526	Injection, therapeutic (eg, local anesthetic; corticosteroid), carpal tunnel	18.00		3.0+T
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	8.00		3.0+T
	(If imaging guidance is performed, see 76003, 76393, 76942)			
20551	single tendon origin/insertion	18.00		3.0+T
20552	single or multiple trigger point(s), one or two muscle(s)	18.00		3.0+T
20553	single or multiple trigger point(s), three or more muscle(s)	18.00		3.0+T
20600	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	8.00		3.0+T
20605	intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	12.00		3.0+T
20610	major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	12.00		3.0+T
	(If imaging guidance is performed, see 76003, 76360, 76393, 76942)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
20612	Aspiration and/or injection of ganglion cyst(s) any location	12.00		3.0+T
20615	Aspiration and injection for treatment of bone cyst	12.00	7	3.0+T
20650	Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)	20.00		3.0+T
20660	Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)	80.00		3.0+T
20661	Application of halo, including removal; cranial	80.00	90	3.0+T
20662	pelvic	80.00	90	3.0+T
20663	femoral	80.00	90	3.0+T
20664	Application of Halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta), requiring general anesthesia	80.00	90	3.0+T
20665	Removal of tongs or halo applied by another physician	4.00	10	3.0+T
20670	Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)	8.00	10	3.0+T
20680	deep, (eg, buried wire, pin, screw, metal band, nail, rod or plate)	75.00	90	3.0+T
20690	Application of a uniplane (pins or wires in one plane), unilateral, external fixation system (List 20690 in addition to code for treatment of closed or open fracture)	80.00	90	3.0+T
20692	Application of a multiplane (pins or wires in more than one plane),unilateral, external fixation system (eg, Ilizarov, Monticelli type) (List 20692 in addition to code for treatment of fracture or joint injury unless listed as part of basic procedure)	150.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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))	90.00	90	3.0+T
20694	Removal, under anesthesia, of external fixation system	110.00	90	3.0+T

REPLANTATION

20802	Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation	820.00	120	5.0+T
20805	Replantation, forearm, (includes radius and ulna to radial carpal joint), complete amputation	1,090.00	120	5.0+T
20808	Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation	1,220.00	120	5.0+T
20816	Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation	780.00	120	5.0+T
20822	Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation	675.00	120	5.0+T
20824	Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputation	730.00	120	5.0+T
20827	Replantation, thumb (includes distal tip to MP joint), complete amputation	740.00	120	5.0+T
20838	Replantation, foot, complete amputation	820.00	120	5.0+T

GRAFTS (OR IMPLANTS)

Codes for obtaining autogenous bone, cartilage, tendon, fascia lata grafts, or other tissues, through separate incisions are to be used only when graft is not already listed as part of basic procedure. Do not append modifier –62 to bone graft codes 20900-20938.

20900	Bone graft, any donor area; minor or small (eg, dowel or button)	180.00	120	3.0+T
20902	major or large	240.00	120	3.0+T
20910	Cartilage graft; costochondral	280.00	120	7.0+T
20912	nasal septum	280.00	120	7.0+T
20920	Fascia lata graft; by stripper	160.00	120	3.0+T
20922	by incision and area exposure, complex or sheet	200.00	120	3.0+T
20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	160.00	120	3.0+T
20926	Tissue grafts, other (eg, paratenon, fat, dermis, etc)	120.00	120	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	(Codes 20930-20938 are reported in addition to codes for the definitive procedure(s). Report only one bone graft code per operative session.)			
20930	Allograft for spine surgery only; morselized	40.00		
20931	structural	41.00		
20936	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision	75.00		
20937	morselized (through separate skin or fascial incision)	63.00		
20938	structural, bicortical or tricortical (through separate skin or fascial incision)	68.00		
	OTHER PROCEDURES			
20950	Monitoring of interstitial fluid pressure (includes insertion of device eg, wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome	20.00		3.0+T
20955	Bone graft with microvascular anastomosis; fibula	400.00	180	3.0+T
20956	iliac crest	180.00	120	3.0+T
20957	metatarsal	180.00	120	3.0+T
20962	other than fibula, iliac crest, or metatarsal	180.00	120	3.0+T
20969	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe	950.00	180	3.0+T
20970	iliac crest	BR		3.0+T
20972	metatarsal	BR		3.0+T
20973	great toe with web space	BR		3.0+T
	(Do not report code 69990 in addition to codes 20969-20973) (For great toe, wrap-around procedure, use 26551)			
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)	12.00		3.0+T
20975	invasive (operative)	75.00		3.0+T
20979	Low intesity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	100.00		
20982	Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance	BR		3.0+T
20999	Unlisted procedure, musculoskeletal system, general	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	HEAD			
	Skull, facial bones and temporomandibular joint			
	INCISION			
	(For drainage of superficial abscess and hematoma, see 20000)			
	(For removal of embedded foreign body from dentoalveolar structure, see 41805, 41806)			
21010	Arthrotomy, temporomandibular joint	300.00	90	5.0+T
	EXCISION			
	(For biopsy, see 20220, 20240)			
21015	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp	139.00	30	3.0+T
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	196.00	90	3.0+T
21026	facial bone(s)	114.00	90	3.0+T
21029	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)	166.00	90	3.0+T
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage	95.00	90	3.0+T
21031	Excision of torus mandibularis	65.00	90	3.0+T
21032	Excision of maxillary torus palatinus	82.00	90	3.0+T
21034	Excision of malignant tumor of maxilla or zygoma	303.00	90	3.0+T
21040	Excision of benign tumor or cyst of mandible, by enucleation and/or curettage	40.50	30	3.0+T
	(For excision of benign tumor or cyst of mandible requiring osteotomy, see 21046-21047)			
21044	Excision of malignant tumor of mandible;	300.00	90	6.0+T
21045	radical resection	430.00	90	6.0+T
	(For bone graft, see 21215)			
21046	Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))	263.00	90	6.0+T
21047	requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))	324.00	90	6.0+T
21048	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy(eg, locally aggressive or destructive lesion(s))	270.00	90	6.0+T
21049	requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))	307.00	90	6.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
21050	Condylectomy, temporomandibular joint; (separate procedure)	300.00	90	6.0+T
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	300.00	90	6.0+T
21070	Coronoidectomy (separate procedure)	160.00	90	6.0+T

INTRODUCTION OR REMOVAL

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

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

21076	Impression and custom preparation; surgical obturator prosthesis	BR	90	3.0+T
21077	orbital prosthesis	BR	90	3.0+T
21079	interim obturator prosthesis	BR	90	3.0+T
21080	definitive obturator prosthesis	BR	90	3.0+T
21081	mandibular resection prosthesis	BR	90	3.0+T
21082	palatal augmentation prosthesis	BR	90	3.0+T
21083	palatal lift prosthesis	BR	90	3.0+T
21084	speech aid prosthesis	BR	90	3.0+T
21085	oral surgical splint	150.00	90	3.0+T
21086	auricular prosthesis	BR	90	3.0+T
21087	nasal prosthesis	BR	90	3.0+T
21088	facial prosthesis	360.00	90	3.0+T
21089	Unlisted maxillofacial prosthetic procedure	BR	90	3.0+T
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)	BR		3.0+T
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal	125.00	90	3.0+T
21116	Injection procedure for temporomandibular joint arthrography	12.00		3.0+T

(For radiological supervision and interpretation, use 70332.
Do not report 76003 in addition to 70332)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	REPAIR, REVISION, AND/OR RECONSTRUCTION			
	(For cranioplasty, see 21179, 21180 and 62116,62120, 62140-62147)			
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	100.00	90	9.0+T
21121	sliding osteotomy, single piece	250.00	90	9.0+T
21122	sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	260.00	90	9.0+T
21123	sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	BR	90	9.0+T
21125	Augmentation, mandibular body or angle; prosthetic material	210.00	90	9.0+T
21127	with bone graft, onlay or interpositional (includes obtaining autograft)	220.00	90	9.0+T
21137	Reduction forehead; contouring only	BR	90	9.0+T
21138	contouring and application of prosthetic material or bone graft (includes obtaining autograft)	320.00	90	9.0+T
21139	contouring and setback of anterior frontal sinus wall	BR	90	9.0+T
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft	380.00	90	9.0+T
21142	two pieces, segment movement in any direction, without bone graft	390.00	90	9.0+T
21143	three or more pieces, segment movement in any direction, without bone graft	400.00	90	9.0+T
21145	single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	390.00	90	9.0+T
21146	two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	400.00	90	9.0+T
21147	three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)	450.00	90	9.0+T
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	BR	90	9.0+T
21151	any direction, requiring bone grafts (includes obtaining autografts)	BR	90	9.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	580.00	90	9.0+T
21155	with LeFort I	620.00	90	9.0+T
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	BR	90	9.0+T
21160	with LeFort I	BR	90	9.0+T
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	530.00	90	9.0+T
	(For frontal or parietal craniotomy for craniosynostosis, see 61556)			
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	630.00	90	9.0+T
	(For bifrontal craniotomy for craniosynostosis, see 61557)			
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	BR	90	9.0+T
21180	with autograft (includes obtaining grafts)	600.00	90	9.0+T
	(For extensive craniectomy for multiple suture craniosynostosis, use only 61558 or 61559)			
21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial	280.00	90	9.0+T
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	BR	90	9.0+T
21183	total area of bone grafting greater than 40 sq cm but less than 80 sq cm	BR	90	9.0+T
21184	total area of bone grafting greater than 80 sq cm	BR	90	9.0+T
	(For excision of benign tumor of cranial bones, see 61563, 61564)			
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	450.00	90	9.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
21193	Reconstruction of mandibular rami, horizontal, vertical, "C", or "L" osteotomy; without bone graft	350.00	90	9.0+T
21194	with bone graft (includes obtaining graft)	BR	90	9.0+T
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	BR	90	9.0+T
21196	with internal rigid fixation	390.00	90	9.0+T
21198	Osteotomy, mandible, segmental;	320.00		
21199	with genioglossus advancement	340.00	90	9.0+T
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	180.00	120	3.0+T
21208	Osteoplasty, facial bones; augmentation (autograft, allograft or prosthetic implant)	280.00	180	3.0+T
21209	reduction	250.00	180	3.0+T
21210	Graft, bone; nasal, maxillary and malar areas (includes obtaining graft) (For cleft palate repair, see 42200-42225)	180.00	180	3.0+T
21215	mandible (includes obtaining graft)	400.00	180	7.0+T
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	280.00	180	7.0+T
21235	ear cartilage, autograft, to nose or ear (includes obtaining graft)	280.00	180	7.0+T
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	380.00	180	7.0+T
21242	Arthroplasty, temporomandibular joint, with allograft	380.00	180	7.0+T
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	BR	180	7.0+T
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	300.00	180	7.0+T
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	300.00	180	7.0+T
21246	complete	400.00	180	7.0+T
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	550.00	90	9.0+T
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	300.00	180	7.0+T
21249	complete	BR	180	7.0+T
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)	600.00	90	9.0+T
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)	600.00	90	9.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach	600.00	90	9.0+T
21261	combined intra- and extracranial approach	BR	90	9.0+T
21263	with forehead advancement	800.00	90	9.0+T
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach	600.00	90	9.0+T
21268	combined intra- and extracranial approach	BR	90	9.0+T
21270	Malar augmentation, prosthetic material	280.00	90	9.0+T
	(For malar augmentation with bone graft, see 21210)			
21275	Secondary revision of orbitocraniofacial reconstruction	300.00	90	9.0+T
21280	Medial canthopexy (separate procedure)	8.00		3.0+T
	(For medial canthoplasty, see 67950)			
21282	Lateral canthopexy	8.00		3.0+T
21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach	BR		3.0+T
21296	intraoral approach	BR		3.0+T
21299	Unlisted craniofacial and maxillofacial procedure	BR		3.0+T
FRACTURE AND/OR DISLOCATION				
21300	Closed treatment of skull fracture without operation	BR		3.0+T
	(For operative repair, see 62000-62010)			
21310	Closed treatment of nasal bone fracture without manipulation	10.00		3.0+T
21315	Closed treatment, nasal bone fracture; without stabilization	20.00		3.0+T
21320	with stabilization	40.00	30	4.0+T
21325	Open treatment of nasal fracture; uncomplicated	100.00	30	4.0+T
21330	complicated, with internal and/or external skeletal fixation	160.00	45	4.0+T
21335	with concomitant open treatment of fractured septum	240.00	45	4.0+T
21336	Open treatment of nasal septal fracture, with or without stabilization	100.00	30	4.0+T
21337	Closed treatment of nasal septal fracture, with or without stabilization	20.00		
21338	Open treatment of nasoethmoid fracture; without external fixation	100.00	30	4.0+T
21339	with external fixation	160.00	45	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus	340.00	90	6.0+T
21343	Open treatment of depressed	200.00	90	6.0+T
21344	Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches	300.00	90	6.0+T
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	120.00	90	4.0+T
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation	200.00	90	4.0+T
21347	requiring multiple open approaches	340.00	90	6.0+T
21348	with bone grafting (includes obtaining graft)	500.00	90	6.0+T
21355	Percutanous treatment of fracture of malar area, including zygomatic arch and malar tripod,with manipulation	20.00		4.0+T
21356	Open treatment of depressed zygomatic arch fracture (eg, Gilles approach)	120.00	60	4.0+T
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	120.00	60	4.0+T
21365	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s)of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches	260.00	90	5.0+T
21366	with bone grafting (includes obtaining graft)	400.00	90	5.0+T
21385	Open treatment of orbital floor blowout fracture; transantral approach(Caldwell-Luc type operations)	360.00	90	7.0+T
21386	periorbital approach	360.00	90	7.0+T
21387	combined approach	360.00	90	7.0+T
21390	periorbital approach, with alloplastic or other implant	360.00	90	7.0+T
21395	periorbital approach with bone graft (includes obtaining graft)	360.00	90	7.0+T
21400	Closed treatment of fracture of orbit, except blowout; without manipulation	10.00		3.0+T
21401	with manipulation	20.00		3.0+T
21406	Open treatment of fracture of orbit except blowout; without implant	100.00	30	4.0+T
21407	with implant	160.00	45	4.0+T
21408	with bone grafting (includes obtaining graft)	350.00	45	4.0+T
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	120.00	90	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
21422	Open treatment of palatal or maxillary fracture (LeFort I type);	340.00	90	6.0+T
21423	complicated (comminuted or involving cranial nerve foramina), multiple approaches	380.00	90	6.0+T
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint	120.00	90	4.0+T
21432	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation	200.00	90	4.0+T
21433	complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	200.00	90	4.0+T
21435	complicated, utilizing internal and/or external fixation techniques(eg, head cap, halo device, and/or intermaxillary fixation)	340.00	90	6.0+T
	(For removal of internal or external fixation device, see 20670)			
21436	complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	BR	90	6.0+T
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	120.00	90	4.0+T
21445	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	200.00	90	4.0+T
21450	Closed treatment of mandibular fracture; without manipulation	10.00		3.0+T
21451	with manipulation	120.00	90	4.0+T
21452	Percutaneous treatment of mandibular fracture, with external fixation	10.00		3.0+T
21453	Closed treatment of mandibular fracture with interdental fixation	120.00	90	4.0+T
21454	Open treatment of mandibular fracture with external fixation	160.00	90	4.0+T
21461	Open treatment of mandibular fracture; without interdental fixation	200.00	90	4.0+T
21462	with interdental fixation	200.00	90	4.0+T
21465	Open treatment of mandibular condylar fracture	200.00	90	4.0+T
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints	160.00	90	4.0+T
21480	Closed treatment of temporomandibular dislocation, initial or subsequent	20.00		3.0+T
21485	complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	BR	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
21490	Open treatment of temporomandibular dislocation	160.00	90	3.0+T
	(For interdental wire fixation, see 21497)			
21495	Open treatment of hyoid fracture	BR	90	4.0+T
	(For treatment of fracture of larynx, see 31584-31586)			
21497	Interdental wiring, for condition other than fracture	BR		3.0+T
21499	Unlisted musculoskeletal procedure, head	BR		3.0+T

NECK (SOFT TISSUES) AND THORAX

(For cervical spine, see 21920 et seq)

(For injection of fracture site or trigger point, see 20550)

INCISION

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

21501	Incision and drainage, deep abscess or hematoma, soft tissues of neck of thorax;	16.00		3.0+T
21502	with partial rib ostectomy	180.00	30	3.0+T
21510	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax	180.00	30	3.0+T

EXCISION

(For bone biopsy, see 20220-20251)

21550	Biopsy, soft tissue of neck or thorax	12.00	15	3.0+T
21555	Excision tumor, soft tissue of neck or thorax; subcutaneous	20.00	30	3.0+T
21556	deep, subfascial, intramuscular	36.00	30	3.0+T
21557	Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or thorax	200.00	30	3.0+T
21600	Excision of rib, partial	100.00	30	3.0+T
	(For radical resection of chest wall and rib cage for tumor, see 19260) (For radical debridement of chest wall and rib cage for injury, see 11040-11044)			
21610	Costotransversectomy (separate procedure)	300.00	90	3.0+T
21615	Excision first and/or cervical rib;	300.00	90	3.0+T
21616	with sympathectomy	420.00	90	3.0+T
21620	Ostectomy of sternum, partial	100.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
21627	Sternal debridement	220.00	90	3.0+T
21630	Radical resection of sternum;	260.00	90	3.0+T
21632	with mediastinal lymphadenectomy	280.00	90	3.0+T
21685	Hyoid myotomy and suspension	265.00	90	3.0+T

REPAIR, REVISION AND/OR RECONSTRUCTION

(For superficial wound, see integumentary system section under REPAIR-SIMPLE)

21700	Division of scalenus anticus; without resection of cervical rib	140.00	60	3.0+T
21705	with resection of cervical rib	200.00	60	5.0+T
21720	Division of sternocleidomastoid for torticollis, open operation; without cast application	140.00	60	3.0+T
	(For transection of spinal accessory and cervical nerves, see 63191, 64722)			
21725	with cast application	149.00	60	3.0+T
21740	Reconstructive repair of pectus excavatum or carinatum; open	360.00	90	9.0+T
21742	minimally invasive approach (Nuss procedure), without thoracoscopy	BR	90	9.0+T
21743	minimally invasive approach (Nuss procedure), with thorascopy	BR	90	9.0+T
21750	Closure of median sternotomy separation with or without debridement (separate procedure)	250.00	90	9.0+T

FRACTURE AND/OR DISLOCATION

21800	Closed treatment of rib fracture, uncomplicated, each	30.00	30	3.0+T
21805	Open treatment of rib fracture without fixation, each	BR		3.0+T
21810	Treatment of rib fracture requiring external fixation (flail chest)	BR		3.0+T
21820	Closed treatment of sternum fracture	30.00	30	
21825	Open treatment of sternum fracture with or without skeletal fixation	200.00	30	3.0+T
	(For sternoclavicular dislocation, see 23520-23532)			
21899	Unlisted procedure, neck or thorax	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

BACK AND FLANK

EXCISION

21920	Biopsy, soft tissue of back or flank; superficial	20.00	15	3.0+T
21925	deep	40.00	30	3.0+T
	(For needle biopsy of soft tissue, see 20206)			
21930	Excision, tumor, soft tissue of back or flank	20.00	30	3.0+T
21935	Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank	260.00	30	3.0+T

SPINE (VERTEBRAL COLUMN)

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

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

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

Vertebral procedures are sometimes followed by arthrodesis and in addition may include bone grafts and instrumentation. When arthrodesis is performed addition to another procedure, the arthrodesis should be reported in addition to the original procedure. Examples are after osteotomy, fracture care, vertebral corpectomy and laminectomy. Since bone grafts and instrumentation are never performed without arthrodesis, they are reported as add-on codes. Arthrodesis, however, may be performed in the absence of other procedures. Example: Treatment of a burst fracture of L2 by corpectomy followed by arthrodesis of Ll-L3, utilizing anterior instrumentation Ll-L3 and structural allograft. Report as 63090,22558-51, 22585, 22845 and 20931.

INCISION

22010	Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic	187.00	90	7.0+T
22015	lumbar, sacral, or lumbosacral	185.00	90	7.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

EXCISION

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

(For injection procedure for myelography, use 62284)

(For injection procedure for diskography, see 62290, 62291)

(For injection procedure, chemonucleolysis, single or multiple level, use 62292)

(For injection procedure for facet joints, see 64470-64476, 64622-64627)

(For bone biopsy, see 20220-20251)

22100	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical	167.00	90	7.0+T
22101	thoracic	173.00	90	7.0+T
22102	lumbar	150.00	90	7.0+T
22103	each additional segment (List separately in addition to primary procedure) (Use 22103 in conjunction with codes 22100, 22101, 22102)	53.00		
22110	Partial excision of vertebral body for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical	250.00	90	7.0+T
22112	thoracic	251.00	90	7.0+T
22114	lumbar	217.00	90	7.0+T
22116	each additional vertebral segment (List separately in addition to primary procedure) (Use 22116 only for codes 22110, 22112, 22114)	53.00		

OSTEOTOMY

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

To report instrumentation procedures, see codes 22840-22855.(Report in addition to code(s) for the definitive procedure(s)). Do not append modifier –62 to spinal instrumentation codes 22840-22848 and 22850-22852.

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

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

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.

22210	Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; cervical	421.00	180	7.0+T
22212	thoracic	416.00	180	7.0+T
22214	lumbar	391.00	180	7.0+T
22216	each additional segment (List separately in addition to primary procedure)	129.00		
22220	Osteotomy of spine, including diskectomy, anterior approach, single vertebral segment; cervical	429.00	180	7.0+T
22222	thoracic	384.00	180	7.0+T
22224	lumbar	407.00	180	7.0+T
22226	each additional segment (List separately in addition to primary procedure) (Use 22226 only for codes 22220,22222,22224)	129.00		

FRACTURE AND/OR DISLOCATION

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

To report instrumentation procedures, see codes 22840-22855. (Report in addition to code(s) for the definitive procedure(s)). Do not append modifier –62 to spinal instrumentation codes 22840-22848 and 22850-22852.

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

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

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

22305	Closed treatment of vertebral process fracture(s)	30.00	30	3.0+T
22310	Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing	50.00	45	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
22315	Closed treatment of vertebral fracture(s) and/or dislocation(s) requiring casting or bracing, with and including casting and/or bracing, with or without anesthesia, by manipulation or traction	160.00	90	3.0+T
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	420.00	90	3.0+T
22319	with grafting	BR	90	3.0+T
22325	Open treatment and/or reduction of vertebral fracture (s) and/or dislocation(s); posterior approach, one fractured vertebrae or dislocated segment; lumbar	292.00	90	3.0+T
22326	cervical	403.00	90	3.0+T
22327	thoracic	390.00	90	3.0+T
22328	each additional fractured vertebrae or dislocated segment (List separately in addition to primary procedure) (Use 22328 in conjunction with codes 22325, 22326, 22327)	105.00		

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

(For decompression of spine following fracture, see 63001-63091)
(For arthrodesis of spine following fracture, see 22548-22632)

MANIPULATION

22505	Manipulation of spine requiring anesthesia, any region	35.00		3.0+T

VERTEBRAL BADY, EMBOLIZATION OR INJECTION

22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	100.00	10	3.0+T
22521	lumbar	100.00	10	3.0+T
22522	each additional thoracic or lumbar vertebral body (List separately in addition to primary procedure) (Use 22522 in conjunction with codes 22520, 22521 as appropriate)	35.00	10	

(For radiological supervision and interpretation, see 76012, 76013)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
22523	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic	140.00	10	7.0+T
22524	lumbar	134.00	10	7.0+T
22525	each additional thoracic or lumbar vertebral body (List separately in addition to primary procedure)	64.00		

ARTHRODESIS

To report instrumentation procedures, see codes 22840-22855. (Report in addition to code(s) for the definitive procedure(s)). Do not append modifier –62 to spinal instrumentation codes 22840-22848 and 22850-22852

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

LATERAL EXTRACAVITARY APPROACH TECHNIQUE

22532	Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic	461.00	90	7.0+T
22533	lumbar	426.00	90	7.0+T
22534	thoracic or lumbar, each additional vertebral segment (List separately in addition to primary procedure)	110.00		

ANTERIOR OR ANTEROLATERAL APPROACH TECHNIQUE

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

For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of an anterior interbody arthrodesis, each surgeon should report his/her distinct operative work by appending the modifier –62 to the procedure code. In this situation, the modifier –62 may be appended to the procedure code(s) 22548-22558 and, as appropriate, to the associated additional interspace add-on code 22585 as long as both surgeons continue to work together as primary surgeons.

22548	Arthrodesis, anterior transoral or extraoral technique, clivus-Cl-C2(atlas-axis), with or without excision of odontoid process	544.00	270	7.0+T

(For intervertebral disk excision by laminotomy or laminectomy, see 63020-63042)
(For arthrodesis, see 22548-22632)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
22554	Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); cervical below C2	436.00	270	7.0+T
22556	thoracic	511.00	270	7.0+T
22558	lumbar	481.00	270	7.0+T
22585	each additional interspace (List separately in addition to primary procedure)	128.00		

POSTERIOR, POSTEROLATERAL OR LATERAL TRANSVERSE PROCESS TECHNIQUE

To report instrumentation procedures, see codes 22840-22855. (Report in addition to code(s) for the definitive procedure(s)). Do not append modifier –62 to spinal instrumentation codes 22840-22848 and 22850-22852.

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

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

22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)	478.00	180	7.0+T
22595	Arthrodesis, posterior technique, atlas-axis (Cl-C2)	479.00	180	7.0+T
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment	402.00	180	7.0+T
22610	thoracic (with or without lateral transverse technique)	379.00	270	7.0+T
22612	lumbar (with or without lateral transverse technique)	474.00	270	7.0+T
22614	each additional vertebral segment (List separately in addition to primary procedure) (Use 22614 only for codes 22600,22610,22612)	140.00		
22630	Arthrodesis, posterior interbody technique, inlcuding laminectomy and/or diskectomy to prepare interspace (other than for decompression) single interspace; lumbar	447.00	180	7.0+T
22632	each additional interspace (List separately in addition to primary procedure) (Use code 22632 only for code 22630)	119.00		

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

SPINE DEFORMITY (EG, SCOLIOSIS, KYPHOSIS)

To report instrumentation procedures, see codes 22840-22855. (Report in addition to code(s) for the definitive procedure(s).) Do not append modifier –62 to spinal instrumentation codes 22840-22848 and 22850-22852.

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

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

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

22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments	453.00	270	7.0+T
22802	7 to 12 vertebral segments	720.00	270	7.0+T
22804	13 or more vertebral segments	800.00	270	7.0+T
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments	570.00	270	7.0+T
22810	4 to 7 vertebral segments	720.00	270	7.0+T
22812	8 or more vertebral segments	800.00	270	7.0+T
22818	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (inlcuding body and posterior elements); single or 2 segments	800.00	90	7.0+T
22819	3 or more segments	800.00	90	7.0+T

EXPLORATION

22830	Exploration of spinal fusion	250.00	270	7.0+T

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.

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

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

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

A vertebral interspace is the non-bony compartment between two adjacent vertebral bodies, which contains the intervertebral disk, and includes the nucleus pulposus, annulus fibrosus, and two cartilagenous endplates.

List codes 22840-22848, 22851 separately, in addition to code for fracture, dislocation or arthrodesis of the spine, 22325, 22326, 22327, 22548-22812.

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	142.00		
22841	Internal spinal fixation by wiring of spinous processes	160.00		
22842	Posterior segmental instrumentation (eg, pedical fixation, dual rods with multiple hooks and sublaminal wires); 3 to 6 vertebral segments	163.00		
22843	7 to 12 vertebral segments	203.00		
22844	13 or more vertebral segments	249.00		
22845	Anterior instrumentation; 2 to 3 vertebral segments	136.00		
22846	4 to 7 vertebral segments	188.00		
22847	8 or more vertebral segments	209.00		
22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum	136.00		
22849	Reinsertion of spinal fixation device	286.00	90	7.0+T
22850	Removal of posterior nonsegmental instrumentation (eg, Harrington rod)	211.00	90	5.0+T
22851	Application of intervertebral biomechanical device(s) (eg, synthetic cages, threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace	152.00		
22852	Removal of posterior segmental instrumentation	213.00	90	5.0+T
22855	Removal of anterior instrumentation	191.00	90	5.0+T
	(For spinal cord monitoring use 95925)			
22899	Unlisted procedure, spine	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

ABDOMEN

EXCISION

22900	Excision, abdominal wall tumor, subfascial (eg, desmoid)	40.00	15	3.0+T
22999	Unlisted procedure, abdomen, musculoskeletal system	BR		3.0+T

SHOULDER

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

INCISION

(For incision and drainage procedures, superficial, see 10060-10160)

23000	Removal of subdeltoid calcareous deposits, open	100.00	60	3.0+T
	(For arthroscopic removal of bursal deposits, use 29999)			
23020	Capsular contracture release (eg, Sever type procedure)	280.00	90	3.0+T
23030	Incision and drainage, shoulder area; deep abscess or hematoma	40.00	15	3.0+T
23031	infected bursa	12.00		3.0+T
23035	Incision, bone cortex (eg,for osteomyelitis or bone abscess), shoulder area	180.00	30	3.0+T
23040	Arthrotomy, glenohumeral joint, including exploration, drainage or removal of foreign body	200.00	90	3.0+T
23044	Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage or removal of foreign body	120.00	60	3.0+T

EXCISION

23065	Biopsy, soft tissues; superficial	20.00	15	3.0+T
23066	deep	40.00	15	3.0+T
	(For needle biopsy of soft tissue, use 20206)			
23075	Excision, soft tissue tumor, shoulder area; subcutaneous	20.00	30	3.0+T
23076	deep, subfascial or intramuscular	40.00	15	3.0+T
23077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area	320.00	30	3.0+T
23100	Arthrotomy, glenohumeral joint, including biopsy	200.00	90	3.0+T
23101	Arthrotomy, acromioclavicular joint or sternoclavicular joint, including biopsy and/or excision of torn cartilage	200.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
23105	Arthrotomy, glenohumeral joint with synovectomy, with or without biopsy	280.00	120	3.0+T
23106	sternoclavicular joint, with synovectomy, with or without biopsy	280.00	120	3.0+T
23107	Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body	200.00	90	3.0+T
23120	Claviculectomy; partial (For arthroscopic procedure, use 29824)	140.00	60	3.0+T
23125	total	260.00	60	3.0+T
23130	Acromioplasty or acromionectomy, partial, with or without coracacromial ligament release	100.00	90	3.0+T
23140	Excision or curettage of bone cyst or benign tumor of clavicle or scapula;	100.00	90	3.0+T
23145	with autograft (includes obtaining graft)	140.00	90	3.0+T
23146	with allograft	140.00	90	3.0+T
23150	Excision or curettage of bone cyst or benign tumor of proximal humerus;	160.00	150	3.0+T
23155	with autograft (includes obtaining graft)	200.00	120	3.0+T
23156	with allograft	200.00	120	3.0+T
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess); clavicle	180.00	30	3.0+T
23172	scapula	180.00	30	3.0+T
23174	humeral head to surgical neck	180.00	30	3.0+T
23180	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); clavicle	100.00	90	3.0+T
23182	scapula	100.00	90	3.0+T
23184	proximal humerus	200.00	150	3.0+T
23190	Ostectomy of scapula, partial (eg, superior medial angle)	100.00	90	3.0+T
23195	Resection humeral head (For replacement with implant, see 23470)	400.00	120	3.0+T
23200	Radical resection of bone tumor; clavicle	400.00	120	3.0+T
23210	scapula	400.00	120	3.0+T
23220	Radical resection for tumor, proximal humerus;	400.00	120	3.0+T
23221	with autograft, (includes obtaining graft)	600.00	180	3.0+T
23222	with prosthetic replacement	590.00	180	3.0+T

INTRODUCTION OR REMOVAL

(For arthrocentesis or needling of bursa, see 20610)

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

23330	Removal of foreign body, shoulder; subcutaneous	8.00		3.0+T
23331	deep (eg, Neer hemiarthroplasty removal)	170.00		3.0+T
23332	complicated (eg, total shoulder)	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
23350	Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography	12.00		3.0+T
	(For radiographic arthrography, radiological supervision and interpretation, use 73040. Fluoroscopy (76003) is inclusive of radiographic arthrography) (When fluoroscopic guided injection is performed for enhanced CT arthrography, use codes 23350, 76003, and 73201 or 73202) (When fluoroscopic guided injection is performed for enhanced MR arthrography, use codes 23350, 76003, and 73222 or 73223) (For enhanced CT or enhanced MRI arthrography, use 76003 and either 73201, 73202, 73222 or 73223)			
REPAIR, REVISION AND/OR RECONSTRUCTION				
23395	Muscle transfer, any type, shoulder or upper arm; single	200.00	120	3.0+T
23397	multiple	240.00	120	3.0+T
23400	Scapulopexy (eg, Sprengel's deformity or for paralysis)	260.00	90	6.0+T
23405	Tenotomy, shoulder area; single tendon	115.00	45	3.0+T
23406	multiple tendons through same incision	175.00	45	3.0+T
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	200.00	90	3.0+T
23412	chronic	200.00	90	3.0+T
	(For arthroscopic procedure, use 29827)			
23415	Coracoacromial ligament release, with or without acromioplastym (For arthroscopic procedure, use 29826)	140.00	90	3.0+T
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	280.00	90	3.0+T
23430	Tenodesis of long tendon of biceps	140.00	90	3.0+T
23440	Resection or transplantation of long tendon of biceps	140.00	90	3.0+T
23450	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation	280.00	90	3.0+T
23455	with labral repair (eg, Bankart procedure)	320.00	90	3.0+T
	(To report arthroscopic thermal capsulorrhaphy, use 29999)			
23460	Capsulorrhaphy, anterior, any type; with bone block	345.00	90	3.0+T
23462	with coracoid process transfer	320.00	90	3.0+T
	(To report open thermal capsulorrhaphy, use 23929)			
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block	280.00	90	3.0+T
	(For sternoclavicular and acromioclavicular reconstruction, see 23530 and 23550)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	350.00	90	3.0+T
23470	Arthroplasty, glenohumeral joint; hemiarthoplasty	320.00	120	3.0+T
23472	total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)	420.00	120	3.0+T
	(For removal of total shoulder implants, see 23331, 23332)			
	(For osteotomy proximal humerus, see 24400)			
23480	Osteotomy, clavicle, with or without internal fixation;	160.00	90	3.0+T
23485	with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)	260.00	120	3.0+T
23490	Prophylactic treatment (nailing, pinning, plating, or wiring) with or without methylmethacrylate; clavicle	300.00		3.0+T
23491	proximal humerus	300.00		3.0+T

FRACTURE AND/OR DISLOCATION

23500	Closed treatment of clavicular fracture; without manipulation	20.00	30	3.0+T
23505	with manipulation	60.00	90	3.0+T
23515	Open treatment of clavicular fracture, with or without internal or external fixation	160.00	120	3.0+T
23520	Closed treatment of sternoclavicular dislocation; without manipulation	40.00	45	3.0+T
23525	with manipulation	40.00	45	3.0+T
23530	Open treatment of sternoclavicular dislocation, acute or chronic;	160.00	120	3.0+T
23532	with fascial graft (includes obtaining graft)	190.00	120	3.0+T
23540	Closed treatment of acromioclavicular dislocation; without manipulation	40.00	45	3.0+T
23545	with manipulation	40.00	45	3.0+T
23550	Open treatment of acromioclavicular dislocation, acute or chronic;	160.00	120	3.0+T
23552	with fascial graft (includes obtaining graft)	190.00	120	3.0+T
23570	Closed treatment of scapular fracture; without manipulation	20.00		3.0+T
23575	with manipulation, with or without skeletal tractior (with or without shoulder joint involvement)	20.00	30	3.0+T
23585	Open treatment of scapular fracture (body, glenoid or acromion) with or without internal fixation	260.00	90	3.0+T
23600	Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation	50.00	45	3.0+T
23605	with manipulation, with or without skeletal traction	120.00	120	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external skeletal fixation, with or without repair of tuberosity(-ies);	200.00	120	3.0+T
23616	with proximal humeral prosthetic replacement	450.00	120	3.0+T
23620	Closed treatment of greater humeral tuberosity fracture; without manipulation	30.00	45	3.0+T
23625	with manipulation	100.00	120	3.0+T
23630	Open treatment of greater humeral tuberosity fracture, with or without internal or external fixation	200.00	120	3.0+T
23650	Closed treatment of shoulder dislocation, with manipulation; without anesthesia	20.00		
23655	requiring anesthesia	20.00		3.0+T
23660	Open treatment of acute shoulder dislocation (Repairs for recurrent dislocations, see 23450-23466)	220.00	120	3.0+T
23665	Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation	20.00		3.0+T
23670	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with or without internal or external fixation	220.00	120	3.0+T
23675	Closed treatment of shoulder dislocation, with surgical or anatomical neck fracture, with manipulation	20.00		3.0+T
23680	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, with or without internal or external fixation	220.00	120	3.0+T
	MANIPULATION			
23700	Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded)	20.00		3.0+T
	ARTHRODESIS			
23800	Arthrodesis, glenohumeral joint;	BR	150	3.0+T
23802	with autogenous graft (includes obtaining graft)	450.00	150	3.0+T
	AMPUTATION			
23900	Interthoracoscapular amputation (forequarter)	400.00	90	11.0+T
23920	Disarticulation of shoulder;	300.00	90	5.0+T
23921	secondary closure or scar revision	40.00	90	5.0+T
23929	Unlisted procedure, shoulder	BR		5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

HUMERUS (UPPER ARM) AND ELBOW

Elbow area includes head and neck of radius and olecranon process

INCISION

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

23930	Incision and drainage upper arm or elbow area; deep abscess or hematoma	16.00		3.0+T
23931	bursa	12.00		3.0+T
23935	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), humerus or elbow	180.00	30	3.0+T
24000	Arthrotomy, elbow, including exploration, drainage or removal of foreign body	200.00	60	3.0+T
24006	Arthrotomy of the elbow, with capsular excision for capsular release (separate procedure)	200.00	60	3.0+T

EXCISION

24065	Biopsy, soft tissue of upper arm or elbow area; superficial	20.00	15	3.0+T
24066	deep (sufascial or intramuscular)	40.00	15	3.0+T
24075	Excision, tumor, soft tissue of upper arm or elbow area; subcutaneous	30.00	15	3.0+T
24076	deep, subfascial or intramuscular	36.00	30	3.0+T
24077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area	275.00	30	3.0+T
24100	Arthrotomy, elbow; with synovial biopsy only	200.00	90	3.0+T
24101	with joint exploration, with or without biopsy, with or without removal of loose or foreign body	200.00	90	3.0+T
24102	with synovectomy	280.00	120	3.0+T
24105	Excision, olecranon bursa	80.00	60	3.0+T
24110	Excision or curettage of bone cyst or benign tumor, humerus;	160.00	120	3.0+T
24115	with autograft (includes obtaining graft)	200.00	120	3.0+T
24116	with allograft	200.00	120	3.0+T
24120	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process;	160.00	120	3.0+T
24125	with autograft (includes obtaining graft)	200.00	12	3.0+T
24126	with allograft	200.00	120	3.0+T
24130	Excision, radial head	140.00	90	3.0+T

(For replacement with implant, see 24366)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
24134	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	180.00	30	3.0+T
24136	radial head or neck	180.00	30	3.0+T
24138	olecranon process	180.00	30	3.0+T
24140	Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis); humerus	200.00	150	3.0+T
24145	radial head or neck	200.00	150	3.0+T
24147	olecranon process	100.00	90	3.0+T
24149	Radical resection of capsule, soft tissue, and heterotopic bone, elbow, with contracture release (separate procedure)	300.00	120	5.0+T
24150	Radical resection for tumor, shaft or distal humerus;	365.00	120	5.0+T
24151	with autograft (includes obtaining graft)	400.00	120	5.0+T
24152	Radical resection for tumor, radial head or neck;	365.00	120	5.0+T
24153	with autograft (includes obtaining graft)	400.00	120	5.0+T
24155	Resection of elbow joint (arthrectomy)	280.00	120	3.0+T

INTRODUCTION OR REMOVAL

(For arthrocentesis or needling of bursa or joint, see 20605)

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

24160	Implant removal; elbow joint	160.00	90	3.0+T
24164	radial head	150.00	90	3.0+T
24200	Removal of foreign body, upper arm or elbow area; subcutaneous	8.00		3.0+T
24201	deep (subfascial or intramuscular)	16.00		3.0+T
24220	Injection procedure for elbow arthrography	12.00		3.0+T
	(For elbow arthrography, see 73085) (For injection of tennis elbow, see 20550)			

REPAIR, REVISION AND/OR RECONSTRUCTION

24300	Manipulation, elbow, under anesthesia	105.00	90	3.0+T
	(For application of external fixation, see 20690 or 20692)			
24301	Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)	200.00	120	3.0+T
24305	Tendon lengthening, upper arm or elbow, each tendon	120.00	90	3.0+T
24310	Tenotomy, open, elbow to shoulder, each tendon	80.00	30	3.0+T
24320	Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)	225.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
24330	Flexor-plasty, elbow,(eg, Steindler type advancement);	90.00	90	3.0+T
24331	with extensor advancement	120.00	90	3.0+T
24332	Tenolysis, triceps	145.00	90	3.0+T
24340	Tenodesis of biceps tendon at elbow (separate procedure)	180.00	90	3.0+T
24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cluff)	166.00	90	3.0+T
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft	250.00	90	3.0+T
24343	Repair lateral collateral ligament, elbow, with local tissue	191.00	90	3.0+T
24344	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)	288.00	90	3.0+T
24345	Repair medial collateral ligament, elbow, with local tissue	191.00	90	3.0+T
24346	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)	288.00	90	3.0+T
24350	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis);	130.00	60	3.0+T
24351	with extensor origin detachment	160.00	60	3.0+T
24352	with annular ligament resection	190.00	60	3.0+T
24354	with stripping	190.00	60	3.0+T
24356	with partial ostectomy	220.00	60	3.0+T
24360	Arthroplasty, elbow; with membrane (eg, fascial)	320.00	120	3.0+T
24361	with distal humeral prosthetic replacement	350.00	120	3.0+T
24362	with implant and fascia lata ligament reconstruction	410.00	120	3.0+T
24363	with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)	460.00	120	3.0+T
24365	Arthroplasty, radial head;	320.00	120	3.0+T
24366	with implant	320.00	120	3.0+T
24400	Osteotomy, humerus, with or without internal fixation	200.00	150	3.0+T
24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)	200.00	150	3.0+T
24420	Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876)	400.00	180	3.0+T
24430	Repair of nonunion or malunion, humerus; without graft (eg, compression technique, etc)	400.00	180	3.0+T
24435	with iliac or other autograft (includes obtaining graft)	600.00	180	3.0+T

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

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
24470	Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus)	180.00	180	3.0+T
24495	Decompression fasciotomy, forearm, with brachial artery exploration	190.00	180	3.0+T
24498	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, humeral shaft	265.00	180	3.0+T
	FRACTURE AND/OR DISLOCATION			
24500	Closed treatment of humeral shaft fracture; without manipulation	40.00	45	3.0+T
24505	with manipulation, with or without skeletal traction	100.00	120	3.0+T
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	180.00	120	3.0+T
24516	Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws	260.00	120	3.0+T
24530	Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; without manipulation	30.00	45	3.0+T
24535	with manipulation, with or without skin or skeletal traction	100.00	120	3.0+T
24538	Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension	200.00	120	3.0+T
24545	Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; without intercondylar extension	200.00	120	3.0+T
24546	with intercondylar extension	200.00	120	3.0+T
24560	Closed treatment of humeral epicondylar fracture, medial or lateral; without manipulation	30.00	45	3.0+T
24565	with manipulation	100.00	120	3.0+T
24566	Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation	154.00	90	3.0+T
24575	Open treatment of humeral epicondylar fracture, medial or lateral, with or without internal or external fixation	200.00	120	3.0+T
24576	Closed treatment of humeral condylar fracture, medial or lateral; without manipulation	30.00	45	3.0+T
24577	with manipulation	80.00	120	3.0+T
24579	Open treatment of humeral condylar fracture, medial or lateral, with or without internal or external fixation	160.00	120	3.0+T
24582	Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation	169.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
24586	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius);	310.00	90	3.0+T
24587	with implant arthroplasty	320.00	90	3.0+T
	(For arthroplasty, elbow see 24360-24363)			
24600	Treatment of closed elbow dislocation; without anesthesia	20.00		
24605	requiring anesthesia	80.00		3.0+T
24615	Open treatment of acute or chronic elbow dislocation	220.00	120	3.0+T
24620	Closed treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with manipulation	80.00	90	3.0+T
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with or without internal or external fixation	220.00	120	3.0+T
24640	Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation	20.00		3.0+T
24650	Closed treatment of radial head or neck fracture; without manipulation	30.00	45	3.0+T
24655	with manipulation	60.00	60	3.0+T
24665	Open treatment of radial head or neck fracture, with or without internal fixation or radial head excision;	140.00	90	3.0+T
24666	with radial head prosthetic replacement	180.00	90	3.0+T
24670	Closed treatment of u1nar fracture, proximal end (olecranon process); without manipulation	40.00	45	3.0+T
24675	with manipulation	40.00	45	3.0+T
24685	Open treatment of u1nar fracture proximal end (olecranon process), with or without internal or external fixation	160.00	120	3.0+T
ARTHRODESIS				
24800	Arthrodesis, elbow joint; local	280.00	150	3.0+T
24802	with autogenous graft (includes obtaining graft)	280.00	150	3.0+T
AMPUTATION				
24900	Amputation, arm through humerus; with primary closure	160.00	90	3.0+T
24920	open, circular (guillotine)	140.00	90	3.0+T
24925	secondary closure or scar revision	20.00		3.0+T
24930	reamputation	160.00	90	3.0+T
24931	with implant	275.00	90	3.0+T
24935	Stump elongation, upper extremity	BR	90	3.0+T
24940	Cineplasty, upper extremity, complete procedure	300.00	150	3.0+T
24999	Unlisted procedure, humerus or elbow	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

FOREARM AND WRIST

(Radius, ulna, carpal bones and joints)

INCISION

25000	Incision, extensor tendon sheath, wrist (eg, deQuervains disease)	80.00	30	3.0+T
25001	Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)	80.00	30	3.0+T
25020	Decompression fasciotomy, forearm and/or wrist, flexor or extensor compartment; without debridement of nonviable muscle and/or nerve	160.00	60	3.0+T
25023	with debridement of nonviable muscle and/or nerve	170.00	60	3.0+T
25024	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve	203.00	90	3.0+T
25025	with debridement of nonviable muscle and/or nerve	328.00	90	3.0+T

(For decompression median nerve or for carpal tunnel syndrome, see 64721)
(For decompression fasciotomy with brachial artery exploration, see 24495)
(For debridement, see also 11000-11044)
(For incision and drainage procedures, superficial, see 10060-10160)

25028	Incision and drainage forearm and/or wrist; deep abscess or hematoma	16.00		3.0+T
25031	bursa	12.00		3.0+T
25035	Incision, deep, bone cortex (eg, for osteomyelitis or bone abscess)	225.00	60	3.0+T
25040	Arthrotomy, radiocarpal or midcarpal joint, with exploration, drainage, or removal of foreign body	160.00	60	3.0+T

EXCISION

25065	Biopsy, soft tissue; superficial	20.00	15	3.0+T
25066	deep (subfascial or intramuscular)	40.00	15	3.0+T
25075	Excision, tumor, soft tissue of forearm and/or wrist area; subcutaneous	36.00	30	3.0+T
25076	deep, subfascial or intramuscular	36.00	30	3.0+T
25077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area	260.00	30	3.0+T
25085	Capsulotomy, wrist (eg, for contracture)	140.00	90	3.0+T
25100	Arthrotomy, wrist joint; with biopsy	160.00	60	3.0+T
25101	with joint exploration, with or without biopsy, with or without removal of loose or foreign body	160.00	60	3.0+T
25105	with synovectomy	200.00	120	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
25107	Arthrotomy, distal radioulnar joint including repair of triangular cartilage, complex	160.00	60	3.0+T
25110	Excision, lesion of tendon sheath	60.00	30	3.0+T
25111	Excision of ganglion, wrist (dorsal or volar); primary	60.00	30	3.0+T
25112	recurrent	80.00	30	3.0+T
	(For hand or finger, see 26160)			
25115	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors	200.00	60	3.0+T
25116	extensors (with or without transposition of dorsal retinaculum)	200.00	60	3.0+T
	(For finger synovectomies, see 26145)			
25118	Synovectomy, extensor tendon sheath, wrist, single compartment;	200.00	120	3.0+T
25119	with resection of distal ulna	300.00	150	3.0+T
25120	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process);	160.00	120	3.0+T
25125	with autograft (includes obtaining graft)	200.00	120	3.0+T
25126	with allograft	200.00	120	3.0+T
	(For excision of cyst/tumor, head or neck of radius or olecranon process, see 24120-24126)			
25130	Excision or curettage of bone cyst or benign tumor of carpal bones;	100.00	90	3.0+T
25135	with autograft (includes obtaining graft)	140.00	90	3.0+T
25136	with allograft	140.00	90	3.0+T
25145	Sequestrectomy (eg, for osteomyelitis or bone abscess)	180.00	30	3.0+T
25150	Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis); ulna	200.00	150	3.0+T
25151	radius	200.00	150	3.0+T
25170	Radical resection for tumor, radius or ulna	300.00	90	3.0+T
25210	Carpectomy; one bone	120.00	90	3.0+T
25215	all bones of proximal row	170.00	90	3.0+T
	(For carpectomy with implant, see 25441-25445)			
25230	Radial styloidectomy (separate procedure)	100.00	90	3.0+T
25240	Excision distal ulna partial or complete (eg, Darrach type or matched resection)	100.00	90	3.0+T
	(For implant replacement, distal ulna, see 25442)			
	(For obtaining fascia for interposition, see 20920, 20922)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	INTRODUCTION OR REMOVAL			
	(For K-wire, pin, or rod insertion/removal, see 20650, 20670, 20680)			
25246	Injection procedure for wrist arthrography	12.00		3.0+T
	(For radiological supervision and interpretation, see 73115. do not report 76003 in addition to 73115)			
	(For foreign body removal, superficial, see 20520)			
25248	Exploration with removal of deep foreign body, forearm or wrist	40.00	15	3.0+T
25250	Removal of wrist prosthesis; (separate procedure)	BR		3.0+T
25251	complicated, including total wrist	BR		3.0+T
25259	Manipulation, wrist, under anesthesia	103.00	90	3.0+T
	(For application of external fixation, see 20690 or 20692)			
	REPAIR, REVISION AND/OR RECONSTRUCTION			
25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle	120.00	120	3.0+T
25263	secondary, single, each tendon or muscle	120.00	120	3.0+T
25265	secondary, with free graft (includes obtaining graft) each tendon or muscle	150.00	120	3.0+T
25270	Repair, tendon or muscle, extensor; forearm and/or wrist; primary, single, each tendon or muscle	72.00	60	3.0+T
25272	secondary, single, each tendon or muscle	72.00	60	3.0+T
25274	secondary, with free graft (includes obtaining graft), each tendon or muscle	120.00	60	3.0+T
25275	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft)(eg, for exterior carpi ulnaris subluxation)	184.00	90	3.0+T
25280	Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist; single, each tendon	120.00	90	3.0+T
25290	Tenotomy, open, flexor or extensor tendon, single, each tendon	60.00	30	3.0+T
25295	Tenolysis, flexor or extensor tendon, single each tendon	100.00	60	3.0+T
25300	Tenodesis at wrist; flexors of fingers	100.00	120	3.0+T
25301	extensors of fingers	80.00	120	3.0+T
25310	Tendon transplantation or transfer, flexor or extensor, single; each tendon	160.00	120	3.0+T
25312	with tendon graft(s) (includes obtaining graft), each tendon	160.00	120	3.0+T
25315	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist;	180.00	120	3.0+T
25316	with tendon(s) transfer	200.00	120	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
25320	Capsulorrhaphy or reconstruction, wrist, open, (eg, capsulodesis,ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability	270.00	120	3.0+T
25332	Arthroplasty, wrist, with or without interposition, with or without external or internal fixation (For obtaining fascia for interposition, see 20920-20922) (For prosthetic replacement arthroplasty, see 25441-25446)	241.00	120	3.0+T
25335	Centralization of wrist on ulna (eg, radial club hand)	250.00	120	3.0+T
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	206.00	120	3.0+T
25350	Osteotomy, radius; distal third	160.00	120	3.0+T
25355	middle or proximal third	160.00	120	3.0+T
25360	Osteotomy; ulna	160.00	120	3.0+T
25365	radius AND ulna	240.00	120	3.0+T
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	200.00	120	3.0+T
25375	radius AND ulna	225.00	120	3.0+T
25390	Osteoplasty, radius OR ulna; shortening	260.00	120	3.0+T
25391	lengthening with autograft	400.00	365	3.0+T
25392	Osteoplasty, radius AND ulna; shortening (excluding 64876)	390.00	120	3.0+T
25393	lengthening with autograft	400.00	365	3.0+T
25394	Osteoplasty, carpal bone, shortening	215.00	120	3.0+T
25400	Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)	230.00	365	3.0+T
25405	with autograft (includes obtaining graft)	260.00	150	3.0+T
25415	Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)	340.00	150	3.0+T
25420	with autograft (includes obtaining graft)	390.00	150	3.0+T
25425	Repair of defect with autograft; radius OR ulna	260.00	150	3.0+T
25426	radius AND ulna	390.00	150	3.0+T
25430	Insertion of vascular pedicle into carpal bone (eg, Hori procedure)	190.00	90	3.0+T
25431	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone	187.00	90	3.0+T
25440	Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)	260.00	150	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
25441	Arthroplasty with prosthetic replacement; distal radius	274.00		3.0+T
25442	distal ulna	200.00		3.0+T
25443	scaphoid carpal (navicular)	223.00		3.0+T
25444	lunate	247.00		3.0+T
25445	trapezium	230.00		3.0+T
25446	distal radius and partial or entire carpus ("total wrist")	418.00		3.0+T
25447	Arthroplasty interposition, intercarpal or carpo-metacarpal joints (For wrist arthroplasty, see 25332)	227.00		3.0+T
25449	Revision of arthroplasty, including removal of implant, wrist joint	245.00		3.0+T
25450	Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna	174.00		3.0+T
25455	distal radius AND ulna	207.00		3.0+T
25490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius	207.00		3.0+T
25491	ulna	216.00		3.0+T
25492	radius AND ulna	266.00		3.0+T
	FRACTURE AND/OR DISLOCATION			
25500	Closed treatment of radial shaft fracture; without manipulation	30.00	45	3.0+T
25505	with manipulation	80.00	120	3.0+T
25515	Open treatment of radial shaft fracture, with or without internal or external fixation	160.00	150	3.0+T
25520	Closed treatment of radial shaft fracture and closed treatment of dislocation of distal radio-ulnar joint (Galeazzi fracture/dislocation)	80.00	120	3.0+T
25525	Open treatment of radial shaft fracture, with internal and/or external fixation and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with or without percutaneous skeletal fixation	200.00	150	3.0+T
25526	Open treatment of radial shaft fracture, with internal and/or external fixation and open treatment, with or without internal or external fixation of distal radio-ulnar joint (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex	200.00	150	3.0+T
25530	Closed treatment of ulnar shaft fracture; without manipulation	40.00	45	3.0+T
25535	with manipulation	80.00	120	3.0+T
25545	Open treatment of ulnar shaft fracture, with or without internal or external fixation	160.00	120	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
25560	Closed treatment of radial and ulnar shaft fractures; without manipulation	50.00	45	3.0+T
25565	with manipulation	100.00	120	3.0+T
25574	Open treatment of radial AND ulnar shaft fractures, with internal or external fixation; of radius OR ulna	160.00	120	3.0+T
25575	of radius and ulna	200.00	120	3.0+T
25600	Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation	40.00	45	3.0+T
25605	with manipulation	60.00	120	3.0+T
25611	Percutaneous skeletal fixation of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation, with or without external fixation	120.00	120	3.0+T
25620	Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation	120.00	120	3.0+T
25622	Closed treatment of carpal scaphoid (navicular) fracture; without manipulation	60.00	45	3.0+T
25624	with manipulation	60.00	45	3.0+T
25628	Open treatment of carpal scaphoid (navicular) fracture, with or without internal or external fixation	140.00	120	3.0+T
25630	Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); without manipulation, each bone	60.00	45	3.0+T
25635	with manipulation, each bone	60.00	45	3.0+T
25645	Open treatment of carpal bone fracture (other than carpal scaphoid (navicular)), each bone	140.00	120	3.0+T
25650	Closed treatment of ulnar styloid fracture	40.00	45	3.0+T
25651	Percutaneous skeletal fixation of ulnar styloid fracture	113.00	90	3.0+T
25652	Open treatment of ulnar styloid fracture	166.00	90	3.0+T
25660	Closed treatment of radiocarpal or intercarpal dislocation, one or more bones, with manipulation	24.00		3.0+T
25670	Open treatment of radiocarpal or intercarpal dislocation, one or more bones	180.00	120	3.0+T
25671	Percutaneous skeletal fixation of distal radioulnar dislocation	137.00	90	3.0+T
25675	Closed treatment of distal radioulnar dislocation with manipulation	28.00		3.0+T
25676	Open treatment of distal radioulnar dislocation, acute or chronic	180.00	120	3.0+T
25680	Closed treatment of trans-scaphoperilunar type of fracture dislocation, with manipulation	60.00	45	3.0+T
25685	Open treatment of trans-scaphoperilunar type of fracture dislocation	140.00	120	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
25690	Closed treatment of lunate dislocation, with manipulation	100.00	120	3.0+T
25695	Open treatment of lunate dislocation	180.00	120	3.0+T
	ARTHRODESIS			
25800	Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)	240.00	120	3.0+T
25805	with sliding graft	255.00	120	3.0+T
25810	with iliac or other autograft (includes obtaining graft)	300.00	120	3.0+T
25820	Arthrodesis, wrist; limited, without bone graft (eg, intercarpal or radiocarpal)	200.00	120	3.0+T
25825	with autograft (includes obtaining graft)	220.00	120	3.0+T
25830	Arthrodesis with distal radioulnar joint and segmental resection of ulna, with or without bone graft(eg, Sauve-Kapandji procedure)	206.00	120	3.0+T
	AMPUTATION			
25900	Amputation, forearm, through radius and ulna;	160.00	90	3.0+T
25905	open, circular (guillotine)	140.00	90	3.0+T
25907	secondary closure or scar revision	20.00		3.0+T
25909	reamputation	160.00	90	3.0+T
25915	Krukenberg procedure	160.00	90	3.0+T
25920	Disarticulation through wrist;	160.00	90	3.0+T
25922	secondary closure or scar revision	20.00		3.0+T
25924	reamputation	160.00	90	3.0+T
25927	Transmetacarpal amputation;	120.00	60	3.0+T
25929	secondary closure or scar revision	20.00		3.0+T
25931	reamputation	120.00	60	3.0+T
25999	Unlisted procedure, forearm or wrist	BR		3.0+T
	HAND AND FINGERS			
	INCISION			
26010	Drainage of finger abscess; simple	8.00		3.0+T
26011	complicated (eg, felon)	20.00		3.0+T
26020	Drainage of tendon sheath, one digit and/or palm, each	12.00		3.0+T
26025	Drainage of palmar bursa; single bursa	120.00	60	3.0+T
26030	multiple bursa	260.00	60	3.0+T
26034	Incision, bone cortex, hand or finger (eg,osteomyelitis or bone abscess)	40.00	15	3.0+T
26035	Decompression fingers and/or hand, injection injury (eg, grease gun)	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
26037	Decompressive fasciotomy, hand (excludes 26035)	120.00	60	3.0+T
	(For injection injury, see 26035)			
26040	Fasciotomy, palmar, (eg, Dupuytren's contracture); percutaneous	40.00	60	3.0+T
26045	open, partial	120.00	60	3.0+T
	(For fasciectomy, see 26121-26125)			
26055	Tendon sheath incision (eg, for trigger finger)	40.00	30	3.0+T
26060	Tenotomy, percutaneous, single, each digit	20.00		3.0+T
26070	Arthrotomy, with exploration, drainage, or removal of foreign body; carpometacarpal joint	120.00	60	3.0+T
26075	metacarpophalangeal joint, each	120.00	60	3.0+T
26080	interphalangeal joint, each	60.00	60	3.0+T
EXCISION				
26100	Arthrotomy with biopsy; carpometacarpal joint, each	120.00	60	3.0+T
26105	metacarpophalangeal joint, each	120.00	60	3.0+T
26110	interphalangeal joint, each	60.00	60	3.0+T
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger; subcutaneous	20.00	30	3.0+T
26116	deep (subfascial or intramuscular)	36.00	30	3.0+T
26117	Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger	230.00	30	3.0+T
26121	Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)	230.00	60	3.0+T
26123	Fasciectomy, partial palmar with release,of single digit including promixal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft);	260.00	60	3.0+T
26125	each additional digit (List separately in addition to primary procedure) (Use 26125 in conjunction with code 26123)	80.00	60	3.0+T
	(For fasciotomy, see 26040-26045)			
26130	Synovectomy, carpometacarpal joint	200.00	120	3.0+T
26135	Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit	220.00	120	3.0+T
26140	Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint	120.00	120	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
26145	Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendor, palm and/or finger, each tendon	120.00	120	3.0+T
	(For tendon sheath synovectomies at wrist, see 25115, 25116			
26160	Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger	40.00	30	3.0+T
	(For wrist ganglion, see 25111, 25112) (For trigger digit, see 26055)			
26170	Excision of tendon, palm, flexor, single (separate procedure), each	100.00	60	3.0+T
26180	Excision of tendon, finger, flexor (separate procedure), each tendon	100.00	60	3.0+T
26185	Sesamoidectomy, thumb or finger (separate procedure)	104.00	60	3.0+T
26200	Excision or curettage of bone cyst or benign tumor of metacarpal;	100.00	90	3.0+T
26205	with autograft (includes obtaining graft)	140.00	90	3.0+T
26210	Excision or curettage of bone cyst or benign tumor of proximal, middle or distal phalanx;	100.00	90	3.0+T
26215	with autograft (includes obtaining graft)	140.00	90	3.0+T
26230	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, for osteomyelitis); metacarpal	100.00	90	3.0+T
26235	proximal or middle phalanx	100.00	90	3.0+T
26236	distal phalanx	100.00	90	3.0+T
26250	Radical resection metacarpal; (eg, tumor)	200.00	90	3.0+T
26255	with autograft (includes obtaining graft)	260.00	90	3.0+T
26260	Radical resection, proximal or middle phalanx of finger (eg, tumor);	200.00	90	3.0+T
26261	with autograft (includes obtaining graft)	260.00	90	3.0+T
26262	Radical resection, distal phalanx of finger (eg, tumor)	200.00	90	3.0+T
	INTRODUCTION OR REMOVAL			
26320	Removal of implant from finger or hand	100.00	120	3.0+T
	(For removal of foreign body in hand or finger, see 20520, 20525)			
	REPAIR, REVISION AND/OR RECONSTRUCTION			
26340	Manipulation, finger joint, under anesthesia, each joint	79.00	90	3.0+T
	(For application of external fixation, see 20690 or 20692)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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	120.00	120	3.0+T
26352	secondary with free graft (includes obtaining graft), each tendon	120.00	120	3.0+T
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon	160.00	120	3.0+T
26357	secondary, without free graft, each tendon	160.00	120	3.0+T
26358	secondary with free graft (includes obtaining graft), each tendon	160.00	120	3.0+T
26370	Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon	120.00	120	3.0+T
26372	secondary with free graft (includes obtaining graft), each tendon	160.00	120	3.0+T
26373	secondary without free graft, each tendon	120.00	120	3.0+T
26390	Excision flexor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod	120.00	120	3.0+T
26392	Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod	190.00	120	3.0+T
26410	Repair, extensor tendon, primary or secondary;without free graft, each tendon	48.00	60	3.0+T
26412	with free graft (includes obtaining graft), each tendon	160.00	120	3.0+T
26415	Excision of extensor tendon, implantation of synthetic rod for delayed tendon graft, hand or finger, each rod	BR		3.0+T
26416	Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod	BR		3.0+T
26418	Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon	48.00	60	3.0+T
26420	with free graft (includes obtaining each tendon graft)	160.00	120	3.0+T
26426	Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); using local tissue(s), including lateral band(s), each finger	160.00	120	3.0+T
26428	with free graft (includes obtaining graft), each finger	160.00	120	3.0+T
26432	Closed treatment of distal extensor tendon insertion, with or without percutaneous pinning (eg, mallet finger)	12.00		3.0+T
26433	Repair extensor tendon, distal insertion, primary or secondary; without graft(eg, mallet finger)	48.00	60	3.0+T
26434	with free graft (includes obtaining graft)	160.00	120	3.0+T
	(For tenovaginotomy for trigger finger, see 26055)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
26437	Realignment of extensor tendon, hand, each tendon	180.00	60	3.0+T
26440	Tenolysis, flexor tendon; palm OR finger, each tendon	100.00	60	3.0+T
26442	palm AND finger, each tendon	120.00	60	3.0+T
26445	Tenolysis, extensor tendon, hand or finger; each tendon	100.00	60	3.0+T
26449	Tenolysis, complex, extensor tendon, finger, including forearm, each tendon	120.00	60	3.0+T
26450	Tenotomy, flexor, palm, open, each tendon	48.00	60	3.0+T
26455	Tenotomy, flexor, finger, open, each tendon	20.00		3.0+T
26460	Tenotomy, extensor, hand or finger, open, each tendon	20.00		3.0+T
26471	Tenodesis; of proximal interphalangeal joint, each joint	100.00	120	3.0+T
26474	for distal joint, each joint	80.00	120	3.0+T
26476	Lengthening of tendon, extensor, hand or finger, each tendon	120.00	90	3.0+T
26477	Shortening of tendon, extensor, hand or finger, each tendon	120.00	90	3.0+T
26478	Lengthening of tendon, flexor, hand or finger, each tendon	120.00	90	3.0+T
26479	Shortening of tendon, flexor, hand or finger, each tendon	120.00	90	3.0+T
26480	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand, without free graft, each tendon	120.00	120	3.0+T
26483	with free tendon graft (includes obtaining graft), each tendon	160.00	120	3.0+T
26485	Transfer or transplant of tendon, palmar; without free tendon graft, each tendon	130.00	120	3.0+T
26489	with free tendon graft (includes obtaining graft), each tendon	160.00	120	3.0+T
26490	Opponensplasty; superficialis tendon transfer type, each tendon	130.00	120	3.0+T
26492	tendon transfer with graft (includes obtaining graft), each tendon	160.00	120	3.0+T
26494	hypothenar muscle transfer	145.00	120	3.0+T
26496	other methods	160.00	120	3.0+T
	(For thumb fusion in opposition, see 26820)			
26497	Transfer of tendon to restore intrinsic function; ring and small finger	160.00	120	3.0+T
26498	all four fingers	200.00	120	3.0+T
26499	Correction claw finger, other methods	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
26500	Reconstruction of tendon pulley, each tendon; with local tissues (separate procedure)	60.00	90	3.0+T
26502	with tendon or fascial graft (includes obtaining graft) (separate procedure)	70.00	90	3.0+T
26504	with tendon prosthesis (separate procedure)	120.00	90	3.0+T
26508	Release of thenar muscle(s) (eg, thumb contracture)	150.00	90	3.0+T
26510	Cross intrinsic transfer, each tendon	BR		3.0+T
26516	Capsulodesis, metacarpophalangeal joint; single digit	80.00	90	3.0+T
26517	two digits	120.00	90	3.0+T
26518	three or four digits	140.00	90	3.0+T
26520	Capsulectomy or capsulotomy; metacarpophalangeal joint, each joint	60.00	60	3.0+T
26525	interphalangeal joint, each joint	60.00	60	3.0+T
26530	Arthroplasty, metacarpophalangeal joint; each joint	120.00	90	3.0+T
26531	with prosthetic implant, each joint	250.00	90	3.0+T
26535	Arthroplasty interphalangeal joint; each joint	120.00	90	3.0+T
26536	with prosthetic implant, each joint	220.00	90	3.0+T
26540	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint	140.00	90	3.0+T
26541	Reconstruction, collateral ligament, metacarpophalangeal joint, single, with tendon or fascial graft (includes obtaining graft)	170.00	90	3.0+T
26542	with local tissue (eg, adductor advancement)	200.00	90	3.0+T
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	140.00	90	3.0+T
26546	Repair non-union, metacarpal or phalanx, (includes obtaining bone graft with or without external or internal fixation)	193.00	90	3.0+T
26548	Repair and reconstruction, finger, volar plate, interphalangeal joint	230.00	90	3.0+T
26550	Pollicization of a digit	300.00	120	3.0+T
26551	Transfer, toe-to-hand with microvascular anastomosis; great toe wrap-around with bone graft (For great toe with web space, use 20973)	BR	120	3.0+T
26553	other than great toe, single	BR	120	3.0+T
26554	other than great toe, double	BR	120	3.0+T
26555	Transfer, finger to another position without microvascular anastomosis	BR	120	3.0+T
26556	Transfer, free toe joint**,** with microvascular anastomosis	BR	120	3.0+T
26560	Repair of syndactyly (web finger), each web space; with skin flaps	140.00	60	3.0+T
26561	with skin flaps and grafts	180.00	60	3.0+T
26562	complex (eg, involving bone, nails)	200.00	60	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
26565	Osteotomy; metacarpal, each	120.00	120	3.0+T
26567	phalanx of finger, each	120.00	120	3.0+T
26568	Osteoplasty, lengthening, metacarpal or phalanx	BR		3.0+T
26580	Repair cleft hand	BR		3.0+T
26587	Reconstruction of polydactylous digit, soft tissue and bone	60.00	45	3.0+T
	(For excision of polydactylous digit, soft tissue only, use 11200)			
26590	Repair macrodactylia, each digit	200.00	90	3.0+T
26591	Repair, intrinsic muscles of hand, each muscle	140.00	90	3.0+T
26593	Release, intrinsic muscles of hand, each muscle	150.00	90	3.0+T
26596	Excision of constricting ring of finger, with multiple Z-plasties	150.00	90	3.0+T

FRACTURE AND/OR DISLOCATION

26600	Closed treatment of metacarpal fracture, single; without manipulation, each bone	16.00	45	3.0+T
26605	with manipulation, each bone	16.00	45	3.0+T
26607	Closed treatment of metacarpal fracture, with manipulation, with external fixation, each bone	100.00	90	3.0+T
26608	Percutaneous skeletal fixation of metacarpal fracture, each bone	40.00	45	3.0+T
26615	Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone	120.00	90	3.0+T
26641	Closed treatment of carpometacarpal dislocation, thumb, with manipulation	16.00		3.0+T
26645	Closed treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation	16.00		3.0+T
26650	Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with or without external fixation	25.00		3.0+T
26665	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external fixation	80.00	75	3.0+T
26670	Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; without anesthesia	12.00		
26675	requiring anesthesia	12.00		3.0+T
26676	Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb, with manipulation, each joint	150.00	45	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
26685	Open treatment of carpometacarpal dislocation, other than thumb; with or without internal or external fixation, each joint	80.00	90	3.0+T
26686	complex, multiple or delayed reduction	120.00	90	3.0+T
26700	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia	12.00		
26705	requiring anesthesia	12.00		3.0+T
26706	Percutaneous skeletal fixation of metacarpo-phalangeal dislocation, single, with manipulation	40.00	45	3.0+T
26715	Open treatment of metacarpophalangeal dislocation, single, with or without internal or external fixation	80.00	90	3.0+T
26720	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	10.00	45	3.0+T
26725	with manipulation, with or without skin or skeletal traction, each	30.00	45	3.0+T
26727	Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each	30.00	45	3.0+T
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external fixation, each	80.00	60	3.0+T
26740	Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; without manipulation, each	10.00	45	3.0+T
26742	with manipulation, each	12.00	45	3.0+T
26746	Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, with or without internal or external fixation, each	150.00	90	3.0+T
26750	Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each	8.00	45	3.0+T
26755	with manipulation, each	20.00	30	3.0+T
26756	Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each	80.00	45	3.0+T
26765	Open treatment of distal phalangeal fracture, finger or thumb, with or without internal or external fixation, each	50.00	45	3.0+T
26770	Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia	12.00		
26775	requiring anesthesia	12.00		3.0+T
26776	Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation	130.00	45	3.0+T
26785	Open treatment of interphalangeal joint dislocation, with or without internal or external fixation, single	60.00	75	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	ARTHRODESIS			
26820	Fusion in opposition, thumb, with autogenous graft (includes obtaining graft)	220.00	120	3.0+T
26841	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation;	210.00	120	3.0+T
26842	with autograft (includes obtaining graft)	240.00	120	3.0+T
26843	Arthrodesis, carpometacarpal joint, digit, other than thumb, each;	80.00	120	3.0+T
26844	with autograft (includes obtaining graft)	220.00	120	3.0+T
26850	Arthrodesis, metacarpophalangeal joint, with or without internal fixation;	80.00	120	3.0+T
26852	with autograft (includes obtaining graft)	220.00	120	3.0+T
26860	Arthrodesis, interphalangeal joint, with or without internal fixation;	80.00	120	3.0+T
26861	each additional interphalangeal joint (List separately in addition to primary procedure)	40.00		
26862	with autograft (includes obtaining graft)	220.00	120	3.0+T
26863	with autograft (includes obtaining graft), each additional joint (List separately in addition to primary procedure)	110.00		
	AMPUTATION			
	(For hand through metacarpal bones, see 25927)			
26910	Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseus transfer (For repositioning, see 26550, 26555)	120.00	60	3.0+T
26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	60.00	45	3.0+T
26952	with local advancement flap (V-Y, hood) (For repair of soft tissue defect requiring split or full thickness graft or other pedicle flaps, see 15050-15758)	60.00	45	3.0+T
26989	Unlisted procedure, hands or fingers	BR		3.0+T
	PELVIS AND HIP JOINT			
	(Including head and neck of femur)			
	INCISION			
	(For incision/drainage procedures, superficial, see 10060-10160)			
26990	Incision and drainage; deep abscess or hematoma	40.00	15	3.0+T
26991	infected bursa	40.00	15	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
26992	Incision, bone cortex, pelvis and/or hip joint (eg, for osteomyelitis or bone abscess)	180.00	30	3.0+T
27000	Tenotomy, adductor of hip, percutaneous, (separate procedure)	40.00	15	3.0+T
27001	Tenotomy, adductor of hip, open	40.00	15	3.0+T
27003	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy	180.00	60	3.0+T
27005	Tenotomy, hip flexor(s), open (separate procedure)	40.00	15	3.0+T
27006	Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)	40.00	15	3.0+T
27025	Fasciotomy, hip or thigh, any type	220.00	60	3.0+T
27030	Arthrotomy, hip, with drainage (eg, infection)	280.00	90	3.0+T
27033	Arthrotomy, hip, including exploration or removal of loose or foreign body	280.00	90	3.0+T
27035	Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral or obturator nerves	BR		3.0+T
	(For obturator neurectomy, see 64763, 64766)			
27036	Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)	272.00	90	3.0+T
EXCISION				
(For pressure (decubitus) ulcer, see 15920, 15922, 15931-15958)				
27040	Biopsy, soft tissues; superficial	8.00		3.0+T
27041	deep	40.00	15	3.0+T
	(For needle biopsy of soft tissue, use 20206)			
27047	Excision, tumor, pelvis and hip area subcutaneous tissue	20.00	30	3.0+T
27048	deep, subfascial, intramuscular	36.00	30	3.0+T
27049	Radical resection of tumor, soft tissue of pelvis and hip area, (eg, malignant neoplasm)	290.00	30	3.0+T
27050	Arthrotomy, with biopsy; sacroiliac joint	280.00	90	3.0+T
27052	hip joint	280.00	90	3.0+T
27054	Arthrotomy with synovectomy, hip joint	320.00	120	4.0+T
27060	Excision; ischial bursa	130.00	90	3.0+T
27062	trochanteric bursa or calcification	120.00	90	3.0+T
	(For arthrocentesis or needling of bursa, see 20610)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
27065	Excision of bone cyst or benign tumor; superficial (wing or ilium, symphysis pubis, or greater trochanter of femur) with or without autograft	100.00	120	3.0+T
27066	deep, with or without autograft	200.00	120	5.0+T
27067	with autograft requiring separate incision	200.00	120	3.0+T
27070	Partial excision (craterization, saucerization) (eg, osteotomyelitis or bone abscess); superficial (eg, wing of ilium, symphysis pubis or greater trochanter of femur)	200.00	150	3.0+T
27071	deep (subfascial or intramuscular)	200.00	150	3.0+T
27075	Radical resection of tumor or infection; wing of ilium, one pubic or ischial ramus or symphysis pubis	400.00	120	5.0+T
27076	ilium, including acetabulum, both pubic rami, or ischium and acetabulum	400.00	120	5.0+T
27077	innominate bone, total	400.00	120	5.0+T
27078	ischial tuberosity and greater trochanter of femur	400.00	120	5.0+T
27079	ischial tuberosity and greater trochanter of femur, with skin flaps	420.00	120	5.0+T
27080	Coccygectomy, primary	120.00	90	4.0+T

INTRODUCTION OR REMOVAL

27086	Removal of foreign body, pelvis or hip; subcutaneous tissue	8.00		3.0+T
27087	deep (subfacial or intramuscular)	40.00	15	3.0+T
27090	Removal of hip prosthesis; (separate procedure)	100.00	270	5.0+T
27091	complicated, including total hip prosthesis, methylmethacrylate, with or without insertion of spacer	500.00	270	5.0+T
27093	Injection procedure for hip arthrography; without anesthesia	12.00		
27095	with anesthesia	12.00		3.0+T

(For radiological supervision and interpretation, see 73525)

27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steriod (27096 is to be used only with imaging confirmation of intra-articular needle positioning)	12.00		3.0+T

(For radiological supervision and interpretation, use 73542. If formal arthrography is not performed, recorded, and a formal radiologic report is not issued, use 76005 for fluoroscopic guidance for sacroiliac joint injections)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	REPAIR, REVISION, AND/OR RECONSTRUCTION			
27097	Repair or recession, hamstring, proximal	50.00	45	3.0+T
27098	Transfer, adductor to ischium	200.00	45	3.0+T
27100	Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft)	250.00	45	3.0+T
27105	Transfer paraspinal muscle to hip (includes fascial or tendon extension graft)	BR		3.0+T
27110	Transfer iliopsoas; to greater trochanter of femur	460.00	45	3.0+T
27111	to femoral neck	460.00	45	3.0+T
27120	Acetabuloplasty; (eg, Whitman, Colonna Haygroves, or cup type)	500.00	270	5.0+T
27122	resection, femoral head (Girdlestone procedure)	500.00	270	5.0+T
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)	320.00	270	5.0+T
	(For prosthetic replacement following fracture of hip, use 27236)			
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement, (total hip arthroplasty), with or without autograft or allograft	500.00	270	5.0+T
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	600.00	270	5.0+T
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	700.00	270	5.0+T
27137	acetabular component only, with or without autograft or allograft	550.00	270	5.0+T
27138	femoral component only, with or without allograft	525.00	270	5.0+T
27140	Osteotomy and transfer of greater trochanter of femur (separate procedure)	270.00	180	3.0+T
27146	Osteotomy, iliac, acetabular or innominate bone;	360.00	180	5.0+T
27147	with open reduction of hip	425.00	180	5.0+T
27151	with femoral osteotomy	470.00	180	5.0+T
27156	with femoral osteotomy and with open reduction of hip	500.00	150	5.0+T
27158	Osteotomy, pelvis, bilateral (eg, congenital malformation)	410.00	180	5.0+T
27161	Osteotomy, femoral neck (separate procedure)	400.00	180	3.0+T
27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast	320.00	180	3.0+T
27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)	400.00	180	3.0+T
27175	Treatment of slipped femoral epiphysis; by traction, without reduction	160.00	180	5.0+T
27176	by single or multiple pinning, in situ	320.00	180	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
27177	Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)	320.00	180	5.0+T
27178	closed manipulation with single or multiple pinning	320.00	180	5.0+T
27179	osteoplasty of femoral neck (Heyman type procedure)	400.00	180	5.0+T
27181	osteotomy and internal fixation	400.00	180	5.0+T
27185	Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur	220.00	180	3.0+T
27187	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur	320.00	180	3.0+T
	FRACTURE AND/OR DISLOCATION			
27193	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation	10.00	90	3.0+T
27194	with manipulation, requiring more than local anesthesia	15.00	180	3.0+T
27200	Closed treatment of coccygeal fracture	10.00		3.0+T
27202	Open treatment of coccygeal fracture	BR		3.0+T
27215	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s) (eg, pelvic fracture(s) which do not disrupt the pelvic ring), with internal fixation	260.00	180	3.0+T
27216	Percutaneous skeletal fixation of posterior pelvic ring fracture and/or dislocation (includes ilium, sacroiliac joint and/or sacrum)	310.00	180	3.0+T
27217	Open treatment of anterior ring fracture and/or dislocation with internal fixation, (includes pubic symphysis and/or rami)	310.00	180	3.0+T
27218	Open treatment of posterior ring fracture and/or dislocation with internal fixation (includes ilium, sacroiliac joint and/or sacrum)	410.00	180	3.0+T
27220	Closed treatment of acetabulum (hip socket) fracture(s); without manipulation	40.00	45	3.0+T
27222	with manipulation, with or without skeletal traction	220.00	180	3.0+T
27226	Open treatment of posterior or anterior acetabular wall fracture, with internal fixation	300.00	180	3.0+T
27227	Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation	300.00	180	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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	535.00	180	3.0+T
27230	Closed treatment of femoral fracture, proximal end, neck; without manipulation	100.00	90	3.0+T
27232	with manipulation, with or without skeletal traction	200.00	180	3.0+T
27235	Percutaneous skeletal fixation of femoral fracture, proximal end, neck	320.00	180	5.0+T
27236	Treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	320.00	180	6.0+T
27238	Closed treatment of intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; without manipulation	100.00	90	3.0+T
27240	with manipulation, with or without skin or skeletal traction	180.00	180	3.0+T
27244	Treatment of intertrochanteric, pertrochanteric or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	320.00	180	5.0+T
27245	with intramedullary implant, with or without interlocking screws and/or cerclage	400.00	180	5.0+T
27246	Closed treatment of greater trochanteric fracture, without manipulation	60.00	180	3.0+T
27248	Open treatment of greater trochanteric fracture, with or without internal or external fixation	235.00	180	3.0+T
27250	Closed treatment of hip dislocation, traumatic; without anesthesia	80.00	180	
27252	requiring anesthesia	80.00	180	3.0+T
27253	Open treatment of hip dislocation, traumatic, without internal fixation	240.00	180	3.0+T
27254	Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation	240.00	180	3.0+T
27256	Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; without anesthesia, without manipulation	80.00	45	
27257	with manipulation, requiring anesthesia	80.00	45	3.0+T
27258	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc);	240.00	180	4.0+T
27259	with femoral shaft shortening	400.00	180	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
27265	Closed treatment of post hip arthroplasty dislocation; without anesthesia	80.00	180	
27266	requiring regional or general anesthesia	80.00	180	3.0+T
	MANIPULATION			
27275	Manipulation, hip joint, requiring general anesthesia	24.00		3.0+T
	ARTHRODESIS			
27280	Arthrodesis, sacroiliac joint (including obtaining graft) (To report as bilateral procedure, use modifier -50)	BR		5.0+T
27282	Arthrodesis, symphysis pubis (including obtaining graft)	BR		5.0+T
27284	Arthrodesis, hip joint (includes obtaining graft);	400.00	365	5.0+T
27286	with subtrochanteric osteotomy	420.00	365	5.0+T
	AMPUTATION			
27290	Interpelviabdominal amputation (hind quarter amputation)	BR		11.0+T
27295	Disarticulation of hip	320.00	180	8.0+T
27299	Unlisted procedure, pelvis or hip joint	BR		3.0+T
	FEMUR (THIGH REGION) AND KNEE JOINT			
	(Including tibial plateaus)			
	INCISION			
	(For incision/drainage of abscess/hematoma, superficial, see 10060-10160)			
27301	Incision and drainage of deep abscess, bursa, or hematoma, thigh or knee region	40.00	15	3.0+T
27303	Incision, deep with opening of bone cortex, femur or knee(eg, osteomyelitis or bone abscess)	40.00	15	3.0+T
27305	Fasciotomy, iliotibial (tenotomy), open	120.00	45	3.0+T
	(For combined Ober-Yount fasciotomy, see 27025)			
27306	Tenotomy, percutaneous, adductor or hamstring, single tendon (separate procedure)	60.00	45	3.0+T
27307	multiple tendons	120.00	45	3.0+T
27310	Arthrotomy, knee, with exploration, drainage or removal of foreign body (eg, infection)	200.00	90	3.0+T
27315	Neurectomy, hamstring muscle	BR		3.0+T
27320	Neurectomy, popliteal (gastrocnemius)	30.00	60	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
EXCISION				
27323	Biopsy, soft tissues; superficial	12.00	15	3.0+T
27324	deep (subfacial or intramuscular)	40.00	15	3.0+T
27327	Excision, tumor; thigh or knee area subcutaneous	30.00	30	3.0+T
27328	deep, subfascial, or intramuscular	40.00	15	3.0+T
27329	Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area	310.00	30	3.0+T
27330	Arthrotomy, knee; with synovial biopsy only	200.00	90	3.0+T
27331	including joint exploration, biopsy, or removal of loose or foreign bodies	200.00	90	3.0+T
27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral	200.00	90	3.0+T
27333	medial AND lateral	300.00	90	3.0+T
27334	Arthrotomy, with synovectomy; knee, anterior OR posterior	280.00	120	3.0+T
27335	anterior AND posterior including popliteal area	280.00	120	3.0+T
27340	Excision, prepatellar bursa	80.00	60	3.0+T
27345	Excision of synovial cyst of popliteal space (eg, Baker's cyst)	120.00	60	5.0+T
27347	Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee	101.00	60	3.0+T
27350	Patellectomy or hemipatellectomy	200.00	120	3.0+T
27355	Excision or curettage of bone cyst or benign tumor of femur;	160.00	120	3.0+T
27356	with allograft	200.00	120	3.0+T
27357	with autograft (includes obtaining graft)	200.00	120	3.0+T
27358	with internal fixation (List in addition to code for primary procedure)	100.00	120	3.0+T
27360	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)	200.00	150	3.0+T
27365	Radical resection of tumor, bone, femur or knee	400.00	120	5.0+T
	(For radical resection of tumor, soft tissue, use 27329)			
INTRODUCTION OR REMOVAL				
27370	Injection procedure for knee arthrography	12.00		3.0+T
	(For radiological supervision and interpretation, see 73580)			
27372	Removal foreign body, deep, thigh region or knee area	120.00		3.0+T
	(For removal of knee prosthesis including "total knee", see 27488)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
REPAIR, REVISION, AND/OR RECONSTRUCTION				
27380	Suture of infrapatellar tendon; primary	120.00	120	3.0+T
27381	secondary reconstruction, including fascial or tendon graft	160.00	120	3.0+T
27385	Suture of quadriceps or hamstring muscle rupture; primary	180.00	90	3.0+T
27386	secondary reconstruction, including fascial or tendon graft	200.00	120	3.0+T
27390	Tenotomy, open, hamstring, knee to hip; single tendon	120.00	45	3.0+T
27391	multiple tendons, one leg	160.00	45	3.0+T
27392	multiple tendons, bilateral	240.00	45	3.0+T
27393	Lengthening of hamstring tendon; single tendon	120.00	90	3.0+T
27394	multiple tendons, one leg	160.00	90	3.0+T
27395	multiple tendons, bilateral	240.00	90	3.0+T
27396	Transplant, hamstring tendon to patella; single tendon	200.00	120	3.0+T
27397	multiple tendons	240.00	120	3.0+T
27400	Transfer tendon or muscle, hamstrings to femur (eg, Eggers type procedure)	200.00	120	3.0+T
27403	Arthrotomy with open meniscus repair, knee	200.00	90	3.0+T
	(For arthroscopic repair, use 29882)			
27405	Repair, primary, torn ligament and/or capsule, knee; collateral	220.00	120	3.0+T
27407	cruciate	220.00	120	3.0+T
27409	collateral and cruciate ligaments	340.00	180	3.0+T
27415	Osteochondral allograft, knee, open	380.00	90	3.0+T
27418	Anterior tibial tubercleplasty (eg, Maquet type procedure)	260.00	90	3.0+T
27420	Reconstruction of dislocating patella; (eg, Hauser type procedure)	200.00	90	3.0+T
27422	with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	240.00	90	3.0+T
27424	with patellectomy	240.00	120	3.0+T
27425	Lateral retinacular release open	225.00	120	3.0+T
	(For arthroscopic lateral release, use 29873)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
27427	Ligamentous reconstruction (augmentation), knee; extra-articular	260.00	180	3.0+T
27428	intra-articular (open)	400.00	270	3.0+T
27429	intra-articular (open) and extra-articular	BR	270	3.0+T
	(For primary repair of ligament(s) performed in addition to reconstruction, report 27405, 27407 or 27409 in addition to code 27427, 27428 or 27429)			
27430	Quadricepsplasty (eg, Bennett or Thompson type)	180.00	90	3.0+T
27435	Capsulotomy, posterior release, knee	200.00	120	3.0+T
27437	Arthroplasty, patella; without prosthesis	BR		3.0+T
27438	with prosthesis	BR		3.0+T
27440	Arthroplasty, knee, tibial plateau;	400.00	270	3.0+T
27441	with debridement and partial synovectomy	400.00	270	3.0+T
27442	Arthroplasty, femoral condylesor tibial plateau(s), knee;	400.00	270	3.0+T
27443	with debridement and partial synovectomy	400.00	270	3.0+T
27445	Arthroplasty, knee, hinge prosthesis (eg, Walldius type)	350.00	270	5.0+T
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	350.00	270	5.0+T
27447	medial AND lateral compartments with or without patella resurfacing (total knee replacement)	350.00	270	5.0+T
	(For revision of total knee arthroplasty, see 27487) (For removal of total knee prosthesis, see 27488) (To report 27448-27457 as bilateral procedures, use modifier -50)			
27448	Osteotomy, femur, shaft or supracondylar; without fixation	280.00	180	3.0+T
27450	with fixation	280.00	180	3.0+T
27454	Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft, (eg, Sofield type procedure)	400.00	180	3.0+T
27455	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)); before epiphyseal closure	200.00	150	3.0+T
27457	after epiphyseal closure	220.00	90	3.0+T
27465	Osteoplasty, femur; shortening (excluding 64876)	400.00	180	3.0+T
27466	lengthening	400.00	365	3.0+T
27468	combined, lengthening and shortening with femoral segment transfer	600.00	365	3.0+T
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)	320.00	180	4.0+T
27472	with iliac or other autogenous bone graft (includes obtaining graft)	380.00	180	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
27475	Arrest, epiphyseal, any method (eg, epiphydiodesis); distal femur	220.00	90	3.0+T
27477	tibia and fibula, proximal	220.00	90	3.0+T
27479	combined distal femur, proximal tibia and fibula	300.00	90	3.0+T
27485	Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, for genu varus or valgus)	180.00	180	3.0+T
27486	Revision of total knee arthroplasty, with or without allograft; one component	600.00	180	3.0+T
27487	femoral and entire tibial component	700.00	180	3.0+T
27488	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee	361.00	90	3.0+T
27495	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femur	377.00	90	3.0+T
27496	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);	109.00	90	3.0+T
27497	with debridement of nonviable muscle and/or nerve	133.00	90	3.0+T
27498	Decompression fasciotomy, thigh and/or knee, multiple compartments;	152.00	90	3.0+T
27499	with debridement of nonviable muscle and/or nerve	175.00	90	3.0+T

FRACTURE AND/OR DISLOCATION

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

(For arthroscopic treatment of tibial fracture, see 29855, 29856)

27500	Closed treatment of femoral shaft fracture, without manipulation	60.00	90	3.0+T
27501	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation	60.00	90	3.0+T
27502	Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction	160.00	180	3.0+T
27503	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension; with manipulation, with or without skin or skeletal traction	230.00	180	3.0+T
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	360.00	180	3.0+T
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	310.00	180	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
27508	Closed treatment of femoral fracture, distal end, medial or lateral condyle, without manipulation	70.00	45	3.0+T
27509	Percutaneous skeletal fixation of femoral fracture, distal end, medial or lateral condyle, or supracondylar or transcondylar, with or without intercondylar extension, or distal femoral epiphyseal separation	127.00	180	3.0+T
27510	Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation	140.00	120	3.0+T
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, with or without internal or external fixation	310.00	180	3.0+T
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, with or without internal or external fixation	370.00	180	3.0+T
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation	240.00	150	3.0+T
27516	Closed treatment of distal femoral epiphyseal separation; without manipulation	BR		3.0+T
27517	with manipulation, with or without skin or skeletal traction	BR		3.0+T
27519	Open treatment of distal femoral epiphyseal separation, with or without internal or external fixation	240.00	150	3.0+T
27520	Closed treatment of patellar fracture, without manipulation	40.00	45	3.0+T
27524	Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair	200.00	120	3.0+T
27530	Closed treatment of tibial fracture, proximal (plateau); without manipulation	60.00	45	3.0+T
27532	with or without manipulation, with skeletal traction	100.00	120	3.0+T
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation	190.00	150	3.0+T
27536	bicondylar, with or without internal fixation	220.00	150	3.0+T
27538	Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation	60.00	45	3.0+T
27540	Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without internal or external fixation	220.00	180	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
27550	Closed treatment of knee dislocation; without anesthesia	80.00	90	
27552	requiring anesthesia	80.00	90	3.0+T
27556	Open treatment of knee dislocation, with or without internal or external fixation; without primary ligamentous repair or augmentation/reconstruction	240.00	120	3.0+T
27557	with primary ligamentous repair	360.00	180	3.0+T
27558	with primary ligamentous repair, with augmentation/reconstruction	370.00	180	3.0+T
27560	Closed treatment of patellar dislocation; without anesthesia	12.00		
27562	requiring anesthesia	12.00		3.0+T
	(For recurrent dislocation, see 27420-27424)			
27566	Open treatment of patellar dislocation, with or without partial or total patellectomy	200.00	120	3.0+T

MANIPULATION

27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)	20.00		3.0+T

ARTHRODESIS

27580	Arthrodesis, knee, any technique	320.00	180	3.0+T

AMPUTATION

27590	Amputation, thigh, through femur, any level;	240.00	120	3.0+T
27591	immediate fitting technique including first cast	240.00	120	3.0+T
27592	open, circular (guillotine)	200.00	180	3.0+T
27594	secondary closure or scar revision	20.00		3.0+T
27596	reamputation	240.00	120	3.0+T
27598	Disarticulation at knee	160.00	120	3.0+T
27599	Unlisted procedure, femur or knee	BR		3.0+T

LEG (TIBIA AND FIBULA) AND ANKLE JOINT

INCISION

(For incision/drainage procedures, superficial, see 10060-10160)

(For decompression fasciotomy with debridement, see 27892-27894)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
27600	Decompression fasciotomy, leg; anterior and/or lateral compartments only	120.00	60	3.0+T
27601	posterior compartment(s) only	120.00	60	3.0+T
27602	anterior and/or lateral, and posterior compartment(s)	160.00	60	3.0+T
27603	Incision and drainage; deep abscess or hematoma	16.00		3.0+T
27604	infected bursa	12.00		3.0+T
27605	Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia	20.00		
27606	general anesthesia	20.00		3.0+T
27607	Incision, (eg, osteomyelitis or bone abscess) leg or ankle	180.00	30	3.0+T
27610	Arthrotomy, ankle, including exploration, drainage or removal of foreign body	200.00	90	3.0+T
27612	Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening	180.00	90	3.0+T
EXCISION				
27613	Biopsy, soft tissues; superficial	20.00	15	3.0+T
27614	deep (subfacial or intramuscular)	40.00	15	3.0+T
27615	Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area	200.00	30	3.0+T
27618	Excision, tumor, leg or ankle area; subcutaneous tissue	20.00	30	3.0+T
27619	deep, (subfascial or intramuscular)	36.00	30	3.0+T
27620	Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body	200.00	90	3.0+T
27625	Arthrotomy, with synovectomy, ankle;	200.00	120	3.0+T
27626	including tenosynovectomy	200.00	120	3.0+T
27630	Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion), leg and/or ankle	60.00	30	3.0+T
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula;	160.00	120	3.0+T
27637	with autograft (includes obtaining graft)	200.00	120	3.0+T
27638	with allograft	200.00	120	3.0+T
27640	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis or exostosis); tibia	200.00	150	3.0+T
27641	fibula	200.00	150	3.0+T
27645	Radical resection of tumor, bone; tibia	400.00	120	5.0+T
27646	fibula	400.00	120	5.0+T
27647	talus or calcaneus	100.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	INTRODUCTION OR REMOVAL			
27648	Injection procedure for ankle arthrography	12.00		3.0+T
	(For radiological supervision and interpretation, see 73615) (For ankle arthroscopy, see 29894-29898)			
	REPAIR, REVISION, AND/OR RECONSTRUCTION			
27650	Repair, primary, open or percutaneous ruptured Achilles tendon;	180.00	120	3.0+T
27652	with graft (includes obtaining graft)	210.00	120	3.0+T
27654	Repair, secondary, ruptured Achilles tendon, with or without graft	220.00	120	3.0+T
27656	Repair, fascial defect of leg	60.00	90	3.0+T
27658	Repair or suture of flexor tendon, leg; primary, without graft, each tendon	120.00	120	3.0+T
27659	secondary with or without graft, each tendon	140.00	120	3.0+T
27664	Repair, extensor tendon, leg; primary, without graft, each tendon	48.00	60	3.0+T
27665	secondary with or without graft, each tendon	BR	120	3.0+T
27675	Repair dislocating peroneal tendons; without fibular osteotomy	100.00	90	3.0+T
27676	with fibular osteotomy	170.00	120	3.0+T
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon	100.00	60	3.0+T
27681	multiple tendons (through same incision(s))	120.00	60	3.0+T
27685	Lengthening or shortening of tendon; leg or ankle; single tendon (separate procedure)	120.00	90	3.0+T
27686	multiple tendons (through same incision), each	180.00	90	3.0+T
27687	Gastrocnemius recession (eg, Strayer procedure)	120.00	90	3.0+T
	(Toe extensors are considered as a group to be a single tendon when transplanted into midfoot)			
27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)	160.00	120	3.0+T
27691	deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallicus longus, or peroneal tendon to midfoot or hindfoot)	160.00	120	3.0+T
27692	each additional tendon (List separately in addition to primary procedure)	40.00		3.0+T
27695	Repair, primary, disrupted ligment, ankle; collateral	180.00	180	3.0+T
27696	both collateral ligaments	240.00	180	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
27698	Repair, secondary disrupted ligament,ankle, collateral (eg, Watson-Jones procedure)	240.00	180	3.0+T
27700	Arthroplasty, ankle;	300.00	180	3.0+T
27702	with implant (total ankle)	400.00	180	3.0+T
27703	revision, total ankle	BR		3.0+T
27704	Removal of ankle implant	160.00	180	3.0+T
27705	Osteotomy; tibia	220.00	150	3.0+T
27707	fibula	120.00	120	3.0+T
27709	tibia and fibula	280.00	150	3.0+T
27712	multiple, with realignment on intramedullary rod (eg, Sofield type procedure)	300.00	150	3.0+T
	(For osteotomy to correct genu varus (bowleg) or genu valgus (knock-knee), see 27455-27457)			
27715	Osteoplasty, tibia and fibula, lengthening or shortening	400.00	365	3.0+T
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	270.00	120	3.0+T
27722	with sliding graft	300.00	120	3.0+T
27724	with iliac or other autograft (includes obtaining graft)	400.00	120	3.0+T
27725	by synostosis, with fibula, any method	400.00	120	3.0+T
27727	Repair of congenital pseudarthrosis, tibia	BR		3.0+T
27730	Arrest, epiphyseal (epiphysiodesis), open; distal tibia	220.00	90	3.0+T
27732	distal fibula	220.00	90	3.0+T
27734	distal tibia and fibula	330.00	90	3.0+T
27740	Arrest epiphyseal, (epiphysiodesis), any method; combined, proximal and distal tibia and fibula;	300.00	90	3.0+T
27742	and distal femur	400.00	120	3.0+T
	(For epiphyseal arrest of proximal tibia and fibula, see 27477)			
27745	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia	230.00		3.0+T
	FRACTURE AND/OR DISLOCATION			
27750	Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation	60.00	90	3.0+T
27752	with manipulation, with or without skeletal traction	100.00	180	3.0+T
27756	Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture) (eg, pins or screws)	200.00	180	3.0+T
27758	Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with or without cerclage	300.00	180	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	300.00	180	3.0+T
27760	Closed treatment of medial malleolus fracture; without manipulation	30.00	45	
27762	with manipulation, with or without skin or skeletal traction	60.00	120	3.0+T
27766	Open treatment of medial malleolus fracture, with or without internal or external fixation	160.00	120	3.0+T
27780	Closed treatment of proximal fibula or shaft fracture; without manipulation	30.00	45	3.0+T
27781	with manipulation	30.00	45	3.0+T
27784	Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation	120.00	60	3.0+T
27786	Closed treatment of distal fibular fracture (lateral malleolus); without manipulation	30.00	45	3.0+T
27788	with manipulation	60.00	75	3.0+T
27792	Open treatment of distal fibular fracture (lateral malleolus), with or without internal or external fixation	160.00	120	3.0+T
27808	Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation	50.00	90	3.0+T
27810	with manipulation	100.00	150	3.0+T
27814	Open treatment of bimalleolar ankle fracture, with or without internal or external fixation	200.00	150	3.0+T
27816	Closed treatment of trimalleolar ankle fracture; without manipulation	60.00	90	3.0+T
27818	with manipulation	120.00	150	3.0+T
27822	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip	240.00	150	3.0+T
27823	with fixation of posterior lip	240.00	150	3.0+T
27824	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibal plafond), with or without anesthesia; without manipulation	40.00	90	3.0+T
27825	with skeletal traction and/or requiring manipulation	75.00	90	3.0+T
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of fibula only	200.00	90	3.0+T
27827	of tibia only	200.00	90	3.0+T
27828	of both tibia and fibula	240.00	90	3.0+T
27829	Open treatment of distal tibiofibular joint (syndesmosis disruption, with or without internal or external fixation	140.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
27830	Closed treatment of proximal tibiofibular joint dislocation; without anesthesia	40.00	90	
27831	requiring anesthesia	40.00	90	3.0+T
27832	Open treatment of proximal tibiofibular joint dislocation, with or without internal or external fixation, or with excision of proximal fibula	180.00	90	3.0+T
27840	Closed treatment of ankle dislocation; without anesthesia	40.00	90	
27842	requiring anesthesia, with or without percutaneous skeletal fixation	40.00	90	3.0+T
27846	Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation	200.00	90	3.0+T
27848	with repair or internal or external fixation	180.00	90	3.0+T
MANIPULATION				
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)	16.00		3.0+T
ARTHRODESIS				
27870	Arthrodesis, ankle, open	280.00	180	3.0+T
	(For arthroscopic ankle arthrodesis, use 29899)			
27871	Arthrodesis, tibiofibular joint, proximal or distal	160.00	120	3.0+T
AMPUTATION				
27880	Amputation leg, through tibia and fibula;	200.00	90	3.0+T
27881	with immediate fitting technique including application of first cast	200.00	90	3.0+T
27882	open, circular (guillotine)	160.00	120	3.0+T
27884	secondary closure or scar revision	20.00		3.0+T
27886	reamputation	200.00	90	3.0+T
27888	Amputation, ankle, through malleoli of tibia and fibula (Syme, Pirogoff type procedures), with plastic closure and resection of nerves	200.00	90	3.0+T
27889	Ankle disarticulation	200.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	OTHER PROCEDURES			
27892	Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve	135.00	90	3.0+T
	(For decompression fasciotomy of the leg without debridement, see 27600)			
27893	posterior compartment(s) only, with debridement of nonviable muscle and/or nerve	135.00	90	3.0+T
	(For decompression fasciotomy of the leg without debridement, see 27601)			
27894	anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve	165.00	90	3.0+T
	(For decompression fasciotomy of the leg without debridement, see 27602)			
27899	Unlisted procedure, leg or ankle	BR		3.0+T
	FOOT AND TOES			
	INCISION			
	(For incision and drainage procedures, superficial, see 10060-10160)			
28001	Incision and drainage bursa, foot	12.00		3.0+T
28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	12.00		3.0+T
28003	multiple areas	100.00		3.0+T
28005	Incision, bone cortex (eg, for osteomyelitis or bone abscess), foot	120.00		3.0+T
28008	Fasciotomy, foot and/or toe (see also 28060, 28062, 28250)	40.00	60	3.0+T
28010	Tenotomy, percutaneous, toe; single tendon	20.00		3.0+T
28011	multiple tendons	30.00		3.0+T
	(For open tenotomy, see 28230-28234)			
28020	Arthrotomy, with exploration, drainage or removal of loose or foreign body; intertarsal or tarsometatarsal joint	120.00	90	3.0+T
28022	metatarsophalangeal joint	40.00	60	3.0+T
28024	interphalangeal joint	60.00	60	3.0+T
28030	Neurectomy, intrinsic musculature of foot	80.00	90	3.0+T
28035	Release, tarsal tunnel (posterior tibial nerve decompression)	120.00	45	3.0+T
	(For other nerve entrapments, see 64704, 64722)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
EXCISION				
28043	Excision, tumor, foot; subcutaneous tissue	20.00	15	3.0+T
28045	deep, subfascial, intramuscular	40.00	15	3.0+T
28046	Radical resection of tumor (malignant neoplasm), soft tissue of foot	60.00	30	3.0+T
28050	Arthrotomy with biopsy; intertarsal or tarsometatarsal joint	60.00	60	3.0+T
28052	metatarsophalangeal joint	40.00	60	3.0+T
28054	interphalangeal joint	40.00	60	3.0+T
28060	Fasciectomy, plantar fascia; partial (separate procedure)	120.00	60	3.0+T
28062	radical (separate procedure)	200.00	90	3.0+T
	(For plantar fasciotomy, see 28008, 28250)			
28070	Synovectomy; intertarsal or tarsometatarsal joint, each	100.00	120	3.0+T
28072	metatarsophalangeal joint, each	60.00	120	3.0+T
28080	Excision of interdigital (Morton) neuroma, single, each	60.00	60	3.0+T
28086	Synovectomy, tendon sheath, foot; flexor	105.00	120	3.0+T
28088	extensor	85.00	120	3.0+T
28090	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (cyst or ganglion); foot	60.00	30	3.0+T
28092	toe(s), each	40.00	30	3.0+T
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus;	100.00	90	3.0+T
28102	with iliac or other autograft (includes obtaining graft)	140.00	90	3.0+T
28103	with allograft	140.00	90	3.0+T
28104	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus;	100.00	90	3.0+T
28106	with iliac or other autograft (includes obtaining graft)	140.00	90	3.0+T
28107	with allograft	140.00	90	3.0+T
28108	Excision or curettage of bone cyst or benign tumor, phalanges of foot	100.00	90	3.0+T
	(For ostectomy, partial (eg, hallux valgus, Silver type procedure), see 28290)			
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette)(separate procedure)	80.00	60	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
28111	Ostectomy, complete excision; first metatarsal head	120.00	60	3.0+T
28112	other metatarsal head (second, third or fourth)	70.00	60	3.0+T
28113	fifth metatarsal head	20.00	60	3.0+T
28114	all metatarsal heads, with partial proximal phyalangectomy, excluding first metatarsal (Clayton type procedure)	200.00	60	3.0+T
28116	Ostectomy, excision of tarsal coalition	120.00	90	3.0+T
28118	Ostectomy, calcaneus;	200.00	150	3.0+T
28119	for spur, with or without plantar fascial release	200.00	150	3.0+T
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	100.00	90	3.0+T
28122	tarsal or metatarsal bone except talus or calcaneous	100.00	90	3.0+T
	(For partial excision of talus or calcaneus, use 28120) (For cheilectomy for hallux rigidus, use 28289)			
28124	phalanx of toe	60.00	90	3.0+T
28126	Resection, partial or complete, phalangeal base, each toe	50.00	90	3.0+T
28130	Talectomy (astragalectomy)	220.00	120	3.0+T
28140	Metatarsectomy	100.00	60	3.0+T
28150	Phalangectomy, toe, each toe	60.00	60	3.0+T
28153	Resection, condyle(s), distal end of phalanx, each toe	45.00	60	3.0+T
28160	Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each	60.00	60	3.0+T
28171	Radical resection of tumor, bone; tarsal (except talus or calcaneus)	BR	90	3.0+T
28173	metatarsal	160.00	90	3.0+T
28175	phalanx of toe	120.00	90	3.0+T
	(For talus or calcaneus, see 27647)			
	INTRODUCTION OR REMOVAL			
28190	Remove foreign body, foot; subcutaneous	8.00		3.0+T
28192	deep	16.00		3.0+T
28193	complicated	16.00		3.0+T
	REPAIR, REVISION, AND/OR RECONSTRUCTION			
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	120.00	120	3.0+T
28202	secondary with free graft, each tendon (includes obtaining graft)	160.00	120	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	48.00	60	3.0+T
28210	secondary with free graft, each tendon (includes obtaining graft)	75.00	60	3.0+T
28220	Tenolysis, flexor, foot; single tendon	100.00	60	3.0+T
28222	multiple tendons	120.00	60	3.0+T
28225	Tenolysis, extensor, foot; single tendon	100.00	60	3.0+T
28226	multiple tendons	120.00	60	3.0+T
28230	Tenotomy, open, tendon flexor; foot, single or multiple tendon(s) (separate procedure)	30.00		3.0+T
28232	toe, single tendon (separate procedure)	20.00		3.0+T
28234	Tenotomy, open, extensor, foot or toe, each tendon	20.00		3.0+T
28238	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)	160.00	120	3.0+T
	(For subcutaneous tenotomy, see 28010, 28011) (For transfer or transplant of tendon with muscle redirection or rerouting, see 27690-27692) (For extensor hallucis longus transfer with great toe IP fusion (Jones procedure), see 28760)			
28240	Tenotomy lengthening, or release, abductor hallucis muscle	20.00		3.0+T
28250	Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure)	40.00	60	3.0+T
28260	Capsulotomy, midfoot; medial release only (separate procedure)	120.00	90	3.0+T
28261	with tendon lengthening	120.00	120	3.0+T
28262	extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)	120.00	120	3.0+T
28264	Capsulotomy, midtarsal (eg, Heyman type procedure)	200.00	90	3.0+T
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)	60.00	60	3.0+T
28272	interphalangeal joint, each joint (separate procedure)	40.00	60	3.0+T
28280	Syndactylism, (eg, webbing or Kelikian type procedure)	156.00	60	3.0+T
28285	Correction, hammertoe;(eg, interphalangeal fusion, partial or total phalangectomy)	80.00	120	3.0+T
28286	Correcting cock-up fifth toe, with plastic skin closure (Ruiz-Mora type procedure)	80.00	120	3.0+T
28288	Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head	70.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint	188.00	90	3.0+T
28290	Correction hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (Silver type procedure)	80.00	60	3.0+T
28292	Keller, McBride or Mayo type procedure	120.00	120	3.0+T
28293	resection of joint with implant	80.00	60	3.0+T
28294	with tendon transplants (Joplin type procedure)	140.00	150	3.0+T
28296	with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)	140.00	150	3.0+T
28297	Lapidus type procedure	140.00	150	3.0+T
28298	by phalanx osteotomy	120.00	120	3.0+T
28299	by double osteotomy	140.00	120	3.0+T
28300	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	200.00	150	3.0+T
28302	talus	120.00	120	3.0+T
28304	Osteotomy, tarsal bones, other than calcaneus or talus;	120.00	120	3.0+T
28305	with autograft (includes obtaining graft) (eg, Fowler type)	120.00	120	3.0+T
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	120.00	120	3.0+T
28307	first metatarsal with autograft (other than first toe)	120.00	120	3.0+T
28308	other than first metatarsal, each	120.00	120	3.0+T
28309	Osteotomy, metatarsals, multiple, for cavus foot (eg, Swanson type cavus foot procedure)	BR	120	3.0+T
28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)	120.00	120	3.0+T
28312	other phalanges, any toe	120.00	120	3.0+T
28313	Reconstruction, angular deformity of toe, soft tissue procedures only (overlapping second toe, fifth toe, curly toes)	100.00	120	3.0+T
28315	Sesamoidectomy, first toe (separate procedure)	60.00	60	3.0+T
28320	Repair of nonunion or malunion; tarsal bones	200.00	270	3.0+T
28322	metatarsal, with or without bone graft (includes obtaining graft)	140.00	270	3.0+T
28340	Reconstruction, toe, macrodactyly; soft tissue resection	150.00	120	3.0+T
28341	requiring bone resection	190.00	120	3.0+T
28344	Reconstruction, toe(s); polydactyly	100.00	120	3.0+T
28345	syndactyly, with or without skin graft(s), each web	125.00	120	3.0+T
28360	Reconstruction, cleft foot	300.00	120	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	FRACTURE AND/OR DISLOCATION			
28400	Closed treatment of calcaneal fracture; without manipulation	40.00	45	3.0+T
28405	with manipulation	80.00	120	3.0+T
28406	Percutaneous skeletal fixation of calcaneal fracture, with manipulation	160.00	270	3.0+T
28415	Open treatment of calcaneal fracture, with or without internal or external fixation;	200.00	270	3.0+T
28420	with primary iliac or other autogenous bone graft (includes obtaining graft)	350.00	270	3.0+T
28430	Closed treatment of talus fracture; without manipulation	40.00	45	3.0+T
28435	with manipulation	80.00	120	3.0+T
28436	Percutaneous skeletal fixation of talus fracture, with manipulation	125.00	120	3.0+T
28445	Open treatment of talus fracture, with or without internal or external fixation	220.00	120	3.0+T
28450	Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each	30.00	45	3.0+T
28455	with manipulation, each	40.00	90	3.0+T
28456	Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each	85.00	120	3.0+T
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), with or without internal or external fixation, each	120.00	90	3.0+T
28470	Closed treatment of metatarsal fracture; without manipulation, each	30.00	45	3.0+T
28475	with manipulation, each	40.00	90	3.0+T
28476	Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each	60.00	90	3.0+T
28485	Open treatment of metatarsal fracture, with or without internal or external fixation, each	100.00	90	3.0+T
28490	Closed treatment of fracture great toe, phalanx or phalanges; without manipulation	12.00	30	3.0+T
28495	with manipulation	20.00	60	3.0+T
28496	Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges, with manipulation	40.00	60	3.0+T
28505	Open treatment of fracture great toe, phalanx or phalanges, with or without internal or external fixation	60.00	60	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
28510	Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each	12.00	30	3.0+T
28515	with manipulation, each	20.00	60	3.0+T
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, with or without internal or external fixation, each	50.00	60	3.0+T
28530	Closed treatment of sesamoid fracture	BR	60	3.0+T
28531	Open treatment of sesamoid fracture, with or without internal fixation	BR	90	3.0+T
28540	Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia	40.00	90	
28545	requiring anesthesia	40.00	90	3.0+T
28546	Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation	70.00	90	3.0+T
28555	Open treatment of tarsal bone dislocation, with or without internal or external fixation	180.00	120	3.0+T
28570	Closed treatment of talotarsal joint dislocation; without anesthesia	40.00	90	
28575	requiring anesthesia	40.00	90	3.0+T
28576	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation	70.00	90	3.0+T
28585	Open treatment of talotarsal joint dislocation, with or without internal or external fixation	180.00	180	3.0+T
28600	Closed treatment of tarsometatarsal joint dislocation; without anesthesia	40.00	90	
28605	requiring anesthesia	40.00	90	3.0+T
28606	Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation	70.00	90	3.0+T
28615	Open treatment of tarsometatarsal joint dislocation, with or without internal or external fixation	180.00	120	3.0+T
28630	Closed treatment of metatarsophalangeal joint dislocation; without anesthesia	28.00	45	
28635	requiring anesthesia	28.00	45	3.0+T
28636	Percutaneous skeletal fixation of metatarso phalangeal joint dislocation, with manipulation	70.00	90	3.0+T
28645	Open treatment of metatarsophalangeal joint dislocation, with or without internal or external fixation	100.00	60	3.0+T
28660	Closed treatment of interphalangeal joint dislocation; without anesthesia	8.00		
28665	requiring anesthesia	8.00	30	3.0+T
28666	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation	70.00	90	3.0+T
28675	Open treatment of interphalangeal joint dislocation, with or without internal or external fixation	60.00	45	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	ARTHRODESIS			
28705	Arthrodesis, pantalar	315.00	180	3.0+T
28715	triple	240.00	180	3.0+T
28725	subtalar	200.00	120	3.0+T
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	160.00	120	3.0+T
28735	with osteotomy (eg, flatfoot correction)	160.00	120	3.0+T
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal, navicular-cuneiform (eg, Miller type procedure)	120.00	90	3.0+T
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	125.00	90	3.0+T
28750	Arthrodesis, great toe; metatarsophalangeal joint	160.00	120	3.0+T
28755	interphalangeal joint	60.00	120	3.0+T
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint, (eg, Jones type procedure)	100.00	120	3.0+T
	(For hammertoe operation or interphalangeal fusion, see 28285)			
	AMPUTATION			
28800	Amputation, foot; midtarsal (eg, Chopart type procedure)	140.00	90	3.0+T
28805	transmetatarsal	140.00	90	3.0+T
28810	Amputation, metatarsal, with toe, single	100.00	90	3.0+T
28820	Amputation, toe; metatarsophalangeal joint	40.00	45	3.0+T
28825	interphalangeal joint	40.00	45	3.0+T
	(For amputation of tuft of distal phalanx, use 11752)			
28899	Unlisted procedure, foot or toes	BR		3.0+T

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	80.00	2	3.0+T
	(See 20661-20663 for insertion)			
29010	Application of Risser jacket, localizer, body; only	50.00	2	3.0+T
29015	including head	60.00	2	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
29020	Application of turnbuckle jacket, body; only	50.00	2	3.0+T
29025	including head	60.00	2	3.0+T
29035	Application of body cast, shoulder to hips;	32.00	2	3.0+T
29040	including head, Minerva type	40.00	2	3.0+T
29044	including one thigh	40.00	2	3.0+T
29046	including both thighs	40.00	2	3.0+T
29049	Application, cast; figure of eight	10.00	2	3.0+T
29055	shoulder spica	24.00	2	3.0+T
29058	plaster Velpeau	12.50	2	3.0+T
29065	shoulder to hand (long arm)	12.00	2	3.0+T
29075	elbow to finger (short arm)	8.00	2	3.0+T
29085	hand and lower forearm (gauntlet)	8.00	2	3.0+T
29086	finger (eg, contracture)	8.00	2	3.0+T
	SPLINTS			
29105	Application of long arm splint (shoulder to hand)	12.00	2	3.0+T
29125	Application of short arm splint (forearm to hand); static	8.00	2	3.0+T
29126	dynamic	15.00	2	3.0+T
	LOWER EXTREMITY			
	CASTS			
	(For hip spica (body) cast, including thighs only, see 29046)			
29305	Application of hip spica cast; one leg	28.00	2	3.0+T
29325	one and one-half spica or both legs	32.00	2	3.0+T
29345	Application of long leg cast (thigh to toes);	16.00	2	3.0+T
29355	walker or ambulatory type	16.00	2	3.0+T
29358	Application of long leg cast brace	65.00	2	3.0+T
29365	Application of cylinder cast (thigh to ankle)	10.00	2	3.0+T
29405	Application of short leg cast (below knee to toes);	12.00	2	3.0+T
29425	walking or ambulatory type	14.00	2	3.0+T
29435	Application of patellar tendon bearing (PTB) cast	18.75	2	3.0+T
29440	Adding walker to previously applied cast	5.00	2	
29445	Application of rigid total contact leg cast	40.00	2	3.0+T
29450	Application of clubfoot cast with molding or manipulation, long or short leg	8.00	2	3.0+T
	SPLINTS AND STRAPPING			
29505	Application of long leg splint (thigh to ankle or toes)	12.00	2	3.0+T
29515	Application of short leg splint (calf to foot)	8.00	2	3.0+T
29580	Strapping; Unna boot	8.00	2	3.0+T
29590	Denis-Browne splint strapping	8.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	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	8.00		3.0+T
29705	full arm or full leg cast	8.00		3.0+T
29710	shoulder or hip spica, Minerva, or Risser jacket, etc	8.00		3.0+T
29715	turnbuckle jacket	8.00		3.0+T
29720	Repair of spica, body cast or jacket	12.00		3.0+T
29730	Windowing of cast	3.00	2	3.0+T
29740	Wedging of cast (except clubfoot casts)	4.00	2	3.0+T
29750	Wedging of clubfoot cast	4.00	2	3.0+T
29799	Unlisted procedure, casting or strapping	BR	2	3.0+T
	ENDOSCOPY/ARTHROSCOPY			
	Surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthroscopy.			
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	50.00	60	3.0+T
29804	Arthroscopy, temporomandibular joint, surgical	225.00	90	3.0+T
	(For open procedure, use 21010)			
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)	107.00	90	3.0+T
	(For open procedure, see 23065-23066, 23100-23101)			
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy	297.00	90	3.0+T
	(For open procedure, see 23450-23466) (To report thermal capsulorrhaphy, use 29999)			
29807	repair of slap lesion	290.00	90	3.0+T
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body	225.00	90	3.0+T
	(For open procedure, see 23040-23044, 23107)			
29820	synovectomy, partial	305.00	120	3.0+T
29821	synovectomy, complete	305.00	120	3.0+T
	(For 29820 and 29821, for open procedure, see 23105)			
29822	debridement, limited	225.00	90	3.0+T
29823	debridement, extensive	225.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
29824	Arthroscopy, distal claviculectomy including distal articular surface (Mumford procedure) (For open procedure, use 23120)	182.00	90	3.0+T
29825	with lysis and resection of adhesions with or without manipulation	225.00	90	3.0+T
29826	decompression of subacromial space with partial acromioplasty with or without coracoacromial release (For open procedure, use 23130 or 23415)	200.00	90	3.0+T
29827	with rotator cuff (When arthroscopic subacromial decompression is performed at the same setting, use 29826) (When arthroscopic distal clavicle resection is performed at the same setting, use 29824)	260.00	90	3.0+T
29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)	50.00	60	3.0+T
29834	Arthroscopy, elbow, surgical; with removal of loose body or foreign body	225.00	60	3.0+T
29835	synovectomy, partial	305.00	120	3.0+T
29836	synovectomy, complete	305.00	120	3.0+T
29837	debridement, limited	225.00	60	3.0+T
29838	debridement, extensive	225.00	60	3.0+T
29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)	50.00	60	3.0+T
29843	Arthroscopy, wrist, surgical; for infection, lavage and drainage	225.00	90	3.0+T
29844	synovectomy, partial	305.00	120	3.0+T
29845	synovectomy, complete	305.00	120	3.0+T
29846	excision and/or repair of triangular fibrocartilage and/or joint debridement	225.00	120	3.0+T
29847	Arthroscopy, wrist, surgical; internal fixation for fracture or instability	345.00	180	3.0+T
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament (For open procedure, see 64721)	120.00	45	3.0+T
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)	225.00	90	3.0+T
29851	with internal or external fixation (includes arthroscopy) (For bone graft, use 20900, 20902)	275.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
29855	Arthroscopically aided treatment of tibial fracture, proximal(plateau); unicondylar, with or without internal or external fixation (includes arthroscopy)	250.00	90	3.0+T
29856	bicondylar, with or without internal or external fixation (includes arthroscopy)	295.00	90	3.0+T
29860	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)	174.00	90	3.0+T
29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body	211.00	90	3.0+T
29862	with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum	224.00	90	3.0+T
29863	with synovectomy	225.00	90	3.0+T
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft)	297.00	90	3.0+T
29867	osteochondral allograft (eg, mosaicplasty)	355.00	90	3.0+T
29868	meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	481.00	90	3.0+T
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	50.00	60	3.0+T
29871	Arthroscopy, knee, surgical; for infection, lavage and drainage	225.00	90	3.0+T
29873	with lateral release	225.00	90	3.0+T
	(For open lateral release, use 27425)			
29874	for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)	225.00	90	3.0+T
29875	synovectomy, limited (eg, plica or shelf resection)(separate procedure)	305.00	120	3.0+T
29876	synovectomy, major, two or more compartments (eg, medial or lateral)	305.00	120	3.0+T
29877	debridement/shaving of articular cartilage (chondroplasty)	225.00	90	3.0+T
29879	abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture	425.00	270	3.0+T
29880	with meniscectomy (medial AND lateral, including any meniscal shaving)	335.00	90	3.0+T
29881	with meniscectomy (medial OR lateral, including any meniscal shaving)	225.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
29882	Arthroscopy, knee, surgical;with meniscus repair (medial OR lateral)	225.00	90	3.0+T
29883	with meniscus repair (medial AND lateral)	335.00	90	3.0+T
29884	Arthroscopy, knee, surgical; with lysis of adhesions with or without manipulation (separate procedure)	225.00	90	3.0+T
29885	drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)	400.00	180	3.0+T
29886	drilling for intact osteochondritis dissecans lesion	225.00	90	3.0+T
29887	drilling for intact osteochondritis dissecans lesion with internal fixation	345.00	180	3.0+T
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	285.00	180	3.0+T
29889	Arthroscopically aided posterior cruciate ligament repair/ augmentation or reconstruction	285.00	180	3.0+T
	(Procedures 29888 and 29889 should not be used with reconstruction procedures 27427-27429) (For open ankle arthrodesis, use 27880)			
29891	Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and/or tibia, including drilling of the defect	199.00	90	3.0+T
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	205.00	90	3.0+T
29893	Endoscopic plantar fasciotomy	117.00	90	3.0+T
29894	Arthroscopy ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body	225.00	90	3.0+T
29895	synovectomy, partial	225.00	120	3.0+T
29897	debridement, limited	225.00	90	3.0+T
29898	debridement, extensive	225.00	90	3.0+T
29899	with ankle arthrodesis	225.00	90	3.0+T
29900	Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy (Do not report 29900 with 29901, 29902)	129.00	90	3.0+T
29901	Arthroscopy, metacarpophalangeal joint, surgical; with debridement	142.00	90	3.0+T
29902	with reduction of displaced ulnar collateral ligament (eg, Stenar Lesion)	161.00	90	3.0+T
29999	Unlisted procedure, arthroscopy	BR	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

RESPIRATORY SYSTEM

NOSE

INCISION

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

30000	Drainage abscess or hematoma, nasal, internal approach (For external approach, see 10060, 10140)	8.00		3.0+T
30020	Drainage abscess or hematoma, nasal septum	10.00		3.0+T

EXCISION

30100	Biopsy, intranasal (For biopsy skin of nose, see 11100, 11101)	12.00	7	3.0+T
30110	Excision, nasal polyp(s), simple (Procedure 30110 would normally be completed in an office setting)	28.00	15	3.0+T
30115	Excision, nasal polyp(s), extensive (Procedure 30115 would normally require the facilities available in a hospital setting.)	80.00	30	3.0+T
30117	Excision or destruction, (eg, laser), intranasal lesion; internal approach	80.00	30	3.0+T
30118	external approach (lateral rhinotomy)	120.00	30	3.0+T
30120	Excision or surgical planing of skin of nose for rhinophyma	140.00	60	3.0+T
30124	Excision dermoid cyst, nose; simple, skin, subcutaneous	20.00	30	3.0+T
30125	complex, under bone or cartilage	150.00	60	3.0+T
30130	Excision inferior turbinate, partial or complete, any method	60.00	90	3.0+T
30140	Submucous resection inferior turbinate, partial or complete, any method (For submucous resection of superior or middle turbine, use 30999) (For submucous resection of nasal septum, see 30520)	60.00	90	3.0+T
30150	Rhinectomy; partial	60.00	90	3.0+T
30160	total	80.00	90	3.0+T
	(For closure and/or reconstruction, primary or delayed, see Integumentary System, 13150-13160, 14060-14300, 15120, 15121, 15260, 15261, 15760, 20900-20912)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	INTRODUCTION			
30200	Injection into turbinate(s), therapeutic	8.00		3.0+T
30210	Displacement therapy (Proetz type)	2.50		3.0+T
30220	Insertion, nasal septal prosthesis (button)	25.00		3.0+T
	REMOVAL OF FOREIGN BODY			
30300	Removal foreign body, intranasal; office type procedure	8.00		
30310	requiring general anesthesia	8.00		3.0+T
30320	by lateral rhinotomy	120.00	30	3.0+T
	REPAIR			
	(For obtaining tissues for graft, see 20900-20926, 21210)			
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip (For columellar reconstruction, see 13150 et seq)	160.00	180	3.0+T
30410	complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	320.00	180	3.0+T
30420	including major septal repair	360.00	180	3.0+T
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	60.00	45	3.0+T
30435	intermediate revision (bony work with osteotomies)	320.00	180	3.0+T
30450	major revision (nasal tip work and osteotomies)	360.00	180	3.0+T
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	320.00	180	3.0+T
30462	tip, septum, osteotomies	360.00	180	3.0+T
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction) (30465 is used to report a bilateral procedure) (30465 excludes obtaining graft.) (For graft procedure, see 20900-20926, 21210)	232.00	90	3.0+T
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft (For submucous resection of turbinates, see 30140)	160.00	90	3.0+T
30540	Repair choanal atresia; intranasal	40.00	60	3.0+T
30545	Transpalatine (Do not report modifier –63 in conjunction with 30540, 30545)	240.00	365	3.0+T
30560	Lysis intranasal synechia	8.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
30580	Repair fistula; oromaxillary (Combine with 31030 if antrotomy is included)	80.00	30	3.0+T
30600	oronasal	80.00	30	3.0+T
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)	160.00	90	3.0+T
30630	Repair nasal septal perforations	150.00	60	3.0+T
	DESTRUCTION			
30801	Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method,(separate procedure); superficial	8.00		3.0+T
30802	intramural	8.00		3.0+T
	OTHER PROCEDURES			
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	8.00		3.0+T
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	8.00		3.0+T
30905	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial	40.00		3.0+T
30906	subsequent	8.00		3.0+T
30915	Ligation arteries; ethmoidal	120.00	30	3.0+T
30920	internal maxillary artery, transantral	120.00	30	3.0+T
	(For ligation external carotid artery, see 37600)			3.0+T
30930	Fracture nasal inferior turbinate(s), therapeutic	60.00	90	3.0+T
30999	Unlisted procedure, nose	BR		3.0+T
	ACCESSORY SINUSES			
	INCISION			
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	8.00		3.0+T
31002	sphenoid sinus	12.00		3.0+T
31020	Sinusotomy, maxillary (antrotomy); intranasal	60.00	90	3.0+T
31030	radical (Caldwell-Luc) without removal of antrochoanal polyps	200.00	90	3.0+T
31032	radical (Caldwell-Luc) with removal antrochoanal polyps	200.00	90	3.0+T
31040	Pterygomaxillary fossa surgery, any approach	BR	90	3.0+T
	(For transantral ligation of internal maxillary artery, see 30920)			
31050	Sinusotomy, sphenoid, with or without biopsy;	120.00	90	3.0+T
31051	with mucosal stripping or removal of polyp(s)	140.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
31070	Sinusotomy frontal; external, simple (trephine operation)	80.00	30	3.0+T
31075	transorbital, unilateral (for mucocele or osteoma, Lynch type)	160.00	180	3.0+T
31080	obliterative without osteoplastic flap, brow incision (includes ablation)	320.00	180	3.0+T
31081	obliterative, without osteoplastic flap, coronal incision (includes ablation)	240.00	180	3.0+T
31084	obliterative, with osteoplastic flap, brow incision	240.00	180	3.0+T
31085	obliterative, with osteoplastic flap, coronal incision	240.00	180	3.0+T
31086	nonobliterative, with osteoplastic flap, brow incision	240.00	180	3.0+T
31087	nonobliterative, witH osteoplastic flap, coronal incision	240.00	180	3.0+T
31090	Sinusotomy, unilateral, three or more paranasal sinuses, (frontal, maxillary, ethmoid, sphenoid)	320.00	180	3.0+T

EXCISION

31200	Ethmoidectomy; intranasal, anterior	120.00	90	3.0+T
31201	intranasal, total	120.00	90	3.0+T
31205	extranasal, total	120.00	90	3.0+T
31225	Maxillectomy; without orbital exenteration	400.00	365	3.0+T
31230	with orbital exenteration (en bloc)	460.00	365	3.0+T

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

ENDOSCOPY

A surgical sinus endoscopy always includes a sinusotomy (when appropriate) and diagnostic endoscopy. Codes 31231-31294 are used to report unilateral procedures unless otherwise specified. The codes 31231-31235 for diagnostic evaluation refer to employing a nasal/sinus endoscope to inspect the interior of the nasal cavity and the middle and superior meatus, the turbinates, and the spheno-ethmoid recess. Any time a diagnostic evaluation is performed all these areas would be inspected and a separate code is not reported for each area.

31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	20.00	7	3.0+T
31233	Nasal/sinus endoscopy, diagnostic; with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)	41.00	7	3.0+T
31235	with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)	72.00	7	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	49.00	15	3.0+T
31238	with control of nasal hemorrhage	86.00	15	3.0+T
31239	with dacryocystorhinostomy	233.00	10	3.0+T
31240	with concha bullosa resection	69.00	15	3.0+T
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	121.00	15	3.0+T
31255	with ethmoidectomy, total (anterior and posterior)	183.00	15	3.0+T
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;	80.00	15	3.0+T
31267	with removal of tissue from maxillary sinus	124.00	15	3.0+T
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus	160.00	15	3.0+T
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy;	103.00	15	3.0+T
31288	with removal of tissue from sphenoid sinus	120.00	15	3.0+T
31290	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region	338.00	15	3.0+T
31291	sphenoid region	356.00	15	3.0+T
31292	Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression	275.00	15	3.0+T
31293	with medial orbital wall and inferior orbital wall decompression	301.00	15	3.0+T
31294	with optic nerve decompression	344.00	15	3.0+T
	(For hypophysectomy, transantral or transeptal approach, see 61548; for transcranial hypophysectomy, see 61546)			
31299	Unlisted procedure, accessory sinuses	BR		3.0+T

LARYNX

EXCISION

31300	Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectomy	240.00	365	6.0+T
31320	diagnostic	140.00	60	6.0+T
31360	Laryngectomy; total, without radical neck dissection	400.00	365	6.0+T
31365	total, with radical neck dissection	560.00	365	6.0+T
31367	subtotal supraglottic, without radical neck dissection	400.00	365	6.0+T
31368	subtotal supraglottic, with radical neck dissection	560.00	365	6.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
31370	Partial laryngectomy (hemilaryngectomy); horizontal	240.00	365	6.0+T
31375	laterovertical	240.00	365	6.0+T
31380	anterovertical	240.00	365	6.0+T
31382	antero-latero-vertical	240.00	365	6.0+T
31390	Pharyngolaryngectomy, with radical neck dissection; without reconstruction	560.00	365	6.0+T
31395	with reconstruction	725.00	365	6.0+T
31400	Arytenoidectomy or arytenoidopexy, external approach	280.00	180	6.0+T
	(For endoscopic arytenoidectomy, see 31560)			
31420	Epiglottidectomy	240.00	365	6.0+T
INTRODUCTION				
31500	Intubation, endotracheal, emergency procedure	20.00		4.0+T
	(For injection procedure for bronchography, see 31656, 31708, 31710)			
ENDOSCOPY				
31505	Laryngoscopy, indirect; diagnostic (separate procedure)	16.00	7	4.0+T
31510	with biopsy	16.00	7	4.0+T
31511	with removal of foreign body	16.00	7	4.0+T
31512	with removal of lesion	16.00	7	4.0+T
31513	with vocal cord injection	BR	7	4.0+T
31515	Laryngoscopy, direct, with or without tracheoscopy; for aspiration	40.00	30	4.0+T
31520	diagnostic, newborn (Do not report 31520 with modifier –63)	40.00	30	4.0+T
31525	diagnostic, except newborn	40.00	30	4.0+T
31526	diagnostic, with operating microscope or telescope	140.00	7	4.0+T
31527	with insertion of obturator	BR	30	4.0+T
31528	with dilation, initial	120.00	30	4.0+T
31529	with dilation, subsequent	BR	30	4.0+T
31530	Laryngoscopy, direct, operative, with foreign body removal;	120.00	30	4.0+T
31531	with operating microscope or telescope	160.00	30	4.0+T
31535	Laryngoscopy, direct, operative, with biopsy;	60.00	30	4.0+T
31536	with operating microscope or telescope	160.00	30	4.0+T
31540	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis;	100.00	180	4.0+T
31541	with operating microscope or telescope	160.00	30	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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)	109.00		4.0+T
31546	reconstruction with graft(s) (includes obtaining autograft)	166.00		4.0+T
31560	Laryngoscopy, direct, operative, with arytenoidectomy;	200.00	180	4.0+T
31561	with operating microscope or telescope	200.00	180	4.0+T
31570	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;	120.00	7	4.0+T
31571	with operating microscope or telescope	120.00	7	4.0+T
31575	Laryngoscopy, flexible fiberscopic; diagnostic	40.00	30	4.0+T
31576	with biopsy	60.00	30	4.0+T
31577	with removal of foreign body	120.00	30	4.0+T
31578	with removal of lesion	100.00	180	4.0+T
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	52.00	30	4.0+T

(To report flexible fiberoptic endoscopic evaluation of swallowing, see 92612-92613)
(To report flexible fiberoptic endoscopic evaluation with sensory testing, see 92614-92615)
(To report flexible fiberoptic endoscopic evaluation of swallowing with sensory testing, see 92616-92617)

REPAIR

31580	Laryngoplasty; for laryngeal web, two stage, with keel insertion and removal	360.00	365	6.0+T
31582	for laryngeal stenosis, with graft or core mold, including tracheotomy	460.00	365	6.0+T
31584	with open reduction of fracture	400.00	365	6.0+T
31587	Laryngoplasty, cricoid split	265.00	180	6.0+T
31588	Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy)	310.00	180	6.0+T
31590	Laryngeal reinnervation by neuromuscular pedicle	190.00	180	6.0+T

DESTRUCTION

31595	Section recurrent laryngeal nerve, therapeutic (separate procedure), unilateral	BR		6.0+T
31599	Unlisted procedure, larynx	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

TRACHEA AND BRONCHI

INCISION

31600	Tracheostomy, planned (separate procedure);	80.00	15	4.0+T
31601	under two years	80.00	15	4.0+T
31603	Tracheostomy, emergency procedure; transtracheal	80.00	15	4.0+T
31605	cricothyroid membrane	80.00	15	4.0+T
31610	Tracheostomy, fenestration procedure with skin flaps	200.00	180	4.0+T
	(For endotracheal intubation, see 31500) (For tracheal aspiration under direct vision, see 31515)			
31611	Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)	120.00	90	5.0+T
31612	Tracheal puncture, percutaneous with transtracheal aspiration and/or injection	40.00	30	4.0+T
31613	Tracheostoma revision; simple, without flap rotation	130.00	90	5.0+T
31614	complex, with flap rotation	200.00	90	5.0+T

ENDOSCOPY

Surgical bronchoscopy always includes diagnostic bronchoscopy when performed by the same physician. Codes 31622-31646 include flouroscopic guidance, when performed.

(For tracheoscopy, see laryngoscopy codes 31515-31578)

31615	Tracheobronchoscopy through established tracheostomy incision	60.00	30	4.0+T
31620	Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to primary procedure(s))	60.00		4.0+T
31622	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)	60.00	30	4.0+T
31623	with brushing or protected brushings	66.00	30	4.0+T
31624	with bronchial alveolar lavage	62.00	30	4.0+T
31625	with bronchial or endobronchial biopsy(s), single or multiple sites	80.00	30	4.0+T
31628	with transbronchial lung biopsy(s), single lobe	80.00	30	4.0+T
31629	with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	80.00	30	4.0+T
31630	with tracheal/bronchial dilation or closed reduction of fracture	120.00	30	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
31631	Bronchoscopy, with placement of tracheal stent(s) (includes tracheal/ bronchial dilation as required)	120.00	30	4.0+T
31632	with transbronchial lung biopsy(s), each additional lobe (List separately in addition to primary procedure)	21.00		
31633	with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to primary procedure)	26.00		
31635	with removal of foreign body	100.00	30	4.0+T
31636	with placement of bronchial stent(s) (includes tracheal/ bronchial dilation as required), initial bronchus	60.00		4.0+T
31637	each additional major bronchus stented (List separately in addition to primary procedure)	24.00		4.0+T
31638	with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)	60.00		4.0+T
31640	with excision of tumor	100.00	30	4.0+T
31641	with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)	100.00	30	4.0+T
	(For bronchoscopic photodynamic therapy, report 31641 in addition to 96570, 96571 as appropriate)			
31643	Bronchoscopy, (rigid or flexible); with placement of catheter(s) for intracavitary radioelement application	52.00	30	4.0+T
	(For intracavitary radioelement application, see 77761-77763, 777781-77784)			
31645	with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess)	60.00	30	4.0+T
31646	with therapeutic aspiration of tracheobronchial tree, subsequent	40.00	30	4.0+T
	(For catheter aspiration of tracheobronchial tree at bedside, see 31725)			
31656	with injection of contrast material for segmental bronchography (fiberscope only)	60.00	30	4.0+T
	(For radiological supervision and interpretation, see 71040, 71060)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

INTRODUCTION

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

(For radiological supervision and interpretation for laryngography, see 70373)

(For bronchography, see 71040, 71060)

31700	Catheterization, transglottic (separate procedure)	40.00	30	4.0+T
31708	Instillation of contrast material for laryngography or bronchography, without catheterization	12.00		4.0+T
31710	Catheterization for bronchography, with or without instillation of contrast materia	16.00		4.0+T
	(For bronchoscopic catheterization for bronchography, fiberscope only, see 31656)			
31715	Transtracheal injection for bronchography	12.00		4.0+T
31717	Catheterization with bronchial brush biopsy	80.00	30	4.0+T
31720	Catheter aspiration (separate procedure); nasotreacheal	40.00	30	4.0+T
31725	tracheobronchial with fiberscope, bedside	40.00	30	4.0+T
31730	Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen therapy	40.00	30	4.0+T

REPAIR

31750	Tracheoplasty; cervical	400.00	60	6.0+T
31755	tracheopharyngeal fistulization, each stage	400.00	60	6.0+T
31760	intrathoracic	700.00	60	11.0+T
31766	Carinal reconstruction	BR	60	11.0+T
31770	Bronchoplasty; graft repair	360.00	60	11.0+T
31775	excision stenosis and anastomosis	360.00	60	11.0+T
	(For lobectomy and bronchoplasty, use 32501)			
31780	Excision tracheal stenosis and anastomosis; cervical	400.00	60	6.0+T
31781	cervicothoracic	700.00	60	11.0+T
31785	Excision of tracheal tumor or carcinoma; cervical	400.00	60	6.0+T
31786	thoracic	700.00	60	11.0+T
31800	Suture of tracheal wound or injury; cervical	134.00	30	5.0+T
31805	intrathoracic	256.00	60	11.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
31820	Surgical closure tracheostomy or fistula; without plastic repair	100.00	30	4.0+T
31825	with plastic repair	100.00	30	4.0+T
	(For repair tracheoesophageal fistula, see 43305, 43312)			
31830	Revision of tracheostomy scar	125.00	30	3.0+T
31899	Unlisted procedure, trachea, bronchi	BR		3.0+T

LUNGS AND PLEURA

(For radiological supervision and interpretation, see 76003, 76360, 76942)

INCISION

32000	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent	12.00		3.0+T
32002	Thoracentesis with insertion of tube with or without water seal (eg, for pneumothorax) (separate procedure)	20.00		3.0+T
	(If imaging guidance for 32000 or 32002 is performed, see 76003, 76360, 76942)			
32005	Chemical pleurodesis (eg, for recurrent or persistent pneumothorax)	35.00		3.0+T
32019	Insertion of indwelling tunneled pleural catheter with cuff	200.00		3.0+T
32020	Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)	20.00		3.0+T
	(If imaging guidance is performed, use 75989)			
32035	Thoracostomy; with rib resection for empyema	160.00	90	11.0+T
32036	with open flap drainage for empyema	160.00	90	11.0+T
32095	Thoracotomy, limited, for biopsy of lung or pleura	200.00	90	11.0+T
32100	Thoracotomy, major; with exploration and biopsy	200.00	90	11.0+T
32110	with control of traumatic hemorrhage and/or repair of lung tear	300.00	90	11.0+T
32120	for postoperative complications	300.00	90	11.0+T
32124	with open intrapleural pneumonolysis	300.00	90	11.0+T
32140	with cyst(s) removal, with or without a pleural procedure	300.00	90	11.0+T
32141	with excision- plication of bullae, with or without any pleural procedure	300.00	90	11.0+T
32150	with removal of intrapleural foreign body or fibrin deposit	280.00	90	11.0+T
32151	with removal of intrapulmonary foreign body	300.00	90	11.0+T
32160	with cardiac massage	300.00	90	12.0+T
	(For segmental or other resections of lung, see 32480-32525)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
32200	Pneumonostomy; with open drainage of abscess or cyst	240.00	120	11.0+T
32201	with percutaneous drainage of abcess or cyst	107.00		3.0+T
	(For radiological supervision and interpretation, use 75989)			
32215	Pleural scarification for repeat pneumothorax	300.00	90	11.0+T
32220	Decortication, pulmonary (separate procedure); total	400.00	90	11.0+T
32225	partial	300.00	90	11.0+T
EXCISION				
32310	Pleurectomy; parietal (separate procedure)	200.00	90	11.0+T
32320	Decortication and parietal pleurectomy	500.00	90	11.0+T
32400	Biopsy, pleura; percutaneous needle	20.00		3.0+T
32402	open	200.00	90	11.0+T
32405	Biopsy, lung or mediastinum, percutaneous needle	20.00		3.0+T
	(For procedure 32400 or 32405; for radiological supervision an interpretation see 76003, 76360, 76393, 76942)			
32420	Pneumonocentesis, puncture of lung for aspiration	20.00		3.0+T
32440	Removal of lung, total pneumonectomy	400.00	90	11.0+T
32442	with resection of segment of trachea followed by bronco-tracheal anastomosis (sleeve pneumonectomy)	BR	90	11.0+T
32445	extrapleural	525.00	90	11.0+T
32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	400.00	90	11.0+T
32482	two lobes (bilobectomy)	423.00	90	11.0+T
32484	single segment (segmentectomy)	434.00	90	11.0+T
32486	with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)	462.00	90	11.0+T
32488	all remaining lung following previous removal of a portion of lung (completion pneumonectomy)	500.00	90	11.0+T
32491	excision-plication of emphysematous lung(s), (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure	441.00	90	11.0+T
32500	wedge resection, single or multiple	320.00	90	11.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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)	104.00		
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)	600.00	90	11.0+T
32504	with chest wall reconstruction	700.00	90	11.0+T
32540	Extrapleural enucleation of empyema (empyemectomy);	240.00	90	6.0+T
	ENDOSCOPY			
	(Surgical thoracoscopy always includes diagnostic thorascopy)			
32601	Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, without biopsy	103.00	30	4.0+T
32602	lungs and pleural space, with biopsy	114.00	30	4.0+T
32603	pericardial sac, without biopsy	129.00	30	4.0+T
32604	pericardial sac, with biopsy	144.00	30	4.0+T
32605	mediastinal space, without biopsy	119.00	30	4.0+T
32606	mediastinal space, with biopsy	140.00	30	4.0+T
32650	Thoracoscopy, surgical; with pleurodesis, (eg, mechanical or chemical)	206.00	30	4.0+T
32651	with partial pulmonary decortication	285.00	30	4.0+T
32652	with total pulmonary decortication, including intrapleural pneumonolysis	396.00	30	4.0+T
32653	with removal of intrapleural foreign body or fibrin deposit	269.00	30	4.0+T
32654	with control of traumatic hemorrhage	275.00	30	4.0+T
32655	with excision-plication of bullae, including any pleural procedure	308.00	30	4.0+T
32656	with parietal pleurectomy	302.00	30	4.0+T
32657	with wedge resection of lung, single or multiple	317.00	30	4.0+T
32658	with removal of clot or foreign body from pericardial sac	292.00	30	4.0+T
32659	with creation of pericardial window or partial resection of pericardial sac for drainage	299.00	30	4.0+T
32660	with total pericardectomy	436.00	30	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
32661	Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass	255.00	30	4.0+T
32662	with excision of mediastinal cyst, tumor, or mass	359.00	30	4.0+T
32663	with lobectomy, total or segmental	411.00	30	4.0+T
32664	with thoracic sympathectomy	285.00	30	4.0+T
32665	with esophagomyotomy (Heller type)	345.00	30	4.0+T
	REPAIR			
32800	Repair lung hernia through chest wall	240.00	90	11.0+T
32810	Closure of chest wall following open flap drainage for empyema (Clagett type procedure)	240.00	90	11.0+T
32815	Open closure of major bronchial fistula	300.00	90	11.0+T
32820	Major reconstruction, chest wall (post-traumatic)	BR		11.0+T
	LUNG TRANSPLANTATION			
32851	Lung transplant, single; without cardiopulmonary bypass	985.00	90	15.0+T
32852	with cardiopulmonary bypass	1070.00	90	15.0+T
32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass	1200.00	90	15.0+T
32854	with cardiopulmonary bypass	1260.00	90	15.0+T
	SURGICAL COLLAPSE THERAPY; THORACOPLASTY			
	(For resection of lung, see also 32520-32525)			
	(For resection of first rib for thoracic outlet compression, see 21615, 21616)			
32900	Resection of ribs, extrapleural, all stages	240.00	90	6.0+T
32905	Thoracoplasty, Schede type or extrapleural (all stages);	240.00	90	6.0+T
32906	with closure of bronchopleural fistula	500.00	90	6.0+T
	(For open closure of major bronchial fistula, see 32815)			
32940	Pneumonolysis, extraperiosteal, including filling or packing procedures	240.00	90	6.0+T
32960	Pneumothorax, therapeutic, intrapleural injection of air	20.00		3.0+T
32997	Total lung lavage (unilateral)	95.00		3.0+T
	(For bronchoscopic bronchial alveolar lavage, use 31624)			
32999	Unlisted procedure, lungs and pleura	BR		6.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

CARDIOVASCULAR SYSTEM

Selective vascular catheterizations should be coded to include introduction and all lesser order selective catheterizations used in the approach (eg, the description for a selective right middle cerebral artery catheterization includes the introduction and placement catheterization of the right common and internal carotid arteries). Additional second and/or third order arterial catheterizations within the same family of arteries supplied by a single first order artery should be expressed by 36218 or 36248. Additional first order or higher catheterizations in vascular families supplied by a first order vessel different from a previously selected and coded family should be separately coded using the conventions described above.

(For critical care services, see 99291, 99292)

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

HEART AND PERICARDIUM

PERICARDIUM

33010	Pericardiocentesis; initial	20.00		3.0+T
33011	subsequent	16.00		3.0+T
	(For radiological supervision and interpretation, see 76930)			
33015	Tube pericardiostomy	120.00	90	3.0+T
33020	Pericardiotomy for removal of clot or foreign body (primary procedure)	400.00	90	13.0+T
33025	Creation of pericardial window or partial resection for drainage	400.00	90	13.0+T
33030	Pericardiectomy, subtotal or complete; without cardiopulmonary bypass	480.00	90	15.0+T
33031	with cardiopulmonary bypass	600.00	90	15.0+T
33050	Excision of pericardial cyst or tumor	800.00	90	15.0+T

CARDIAC TUMOR

33120	Excision of intracardiac tumor, resection with cardiopulmonary bypass	800.00	90	15.0+T
33130	Resection of external cardiac tumor	BR		15.0+T

TRANSMYOCARDIAL REVASCULARIZATION

33140	Transmyocardial laser revascularization, by thoracotomy (separate procedure)	377.00	90	15.0+T
33141	performed at the time of other open cardiac procedure(s) (List separately in addition to primary procedure) (Use 33141 in conjunction with codes 33400-33496, 33510-33536, 33542)	188.00		

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.

Like a pacemaker system, a pacing cardioverter defibrillator system also includes a pulse generator and electrodes, although pacing cardioverter-defibrillators may require multiple leads, even when only a single chamber is being paced. A pacing cardioverter-defibrillator system may be inserted in a single chamber (pacing the ventricle) or in dual chambers (pacing the atrium and ventricle). These devices use a combination of antitachycardia pacing, low energy cardioversion or defibrillating shocks to treat ventricular tachycardia or ventricular fibrillation. Pacing cardioverter-defbrillator pulse generators may be implanted in a subcutaneous infraclavicular pocket or in an abdominal pocket. Removal of a pacing cardioverter-defibrillator pulse generator requires opening of the existing subcutaneous pocket and disconnection of the pulse generator from its electrode(s). A thoracotomy (or laparotomy in the case of abdominally placed pulse generators) is not required to remove the pulse generator.

The electrodes (leads) of a pacing cardioverter-defibrillator system are positioned in the heart via the venous system (transvenously), in most circumstances. In certain circumstances, an additional electrode may be required to achieve pacing of the left ventricle (bi-ventricular pacing). In this event, transvenous (cardiac vein) placement of the electrode should be separately reported using code 33224 or 33225. Electrode positioning on the epicardial surface of the heart requires a thoracotomy (codes 33245-33246). 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).

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 the 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.

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	(For electronic, telephonic analysis of pacemaker system, see 93731-93736; for radiological supervision and interpretation with insertion of pacemaker see 71090)			
33200	Insertion of permanent pacemaker with epicardial electrode(s); by thoracotomy	400.00	90	15.0+T
33201	by xiphoid approach	400.00	90	15.0+T
33206	Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial	200.00	90	3.0+T
33207	ventricular	200.00	90	3.0+T
33208	atrial and ventricular	200.00	90	3.0+T
	(Codes 33206-33208 include subcutaneous insertion of the pulse generator and transvenous placement of electrode(s))			
33210	Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure)	125.00		3.0+T
33211	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	76.00		3.0+T
33212	Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular	125.00	90	3.0+T
33213	dual chamber	135.00	90	3.0+T
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)	151.00	90	3.0+T
33215	Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode	89.00	90	3.0+T
33216	Insertion of transvenous electrode; single chamber (one electrode) permanent pacemaker or single chamber pacing cardioverter-defibrillator	116.00	90	3.0+T
33217	dual chamber (two electrodes) permanent pacemaker or dual chamber pacing cardioverter-defibrillator	120.00	90	3.0+T
	(Do not report 33216-33217 in conjunction with code 33214)			
33218	Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator	120.00	90	3.0+T
33220	Repair of two transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator	112.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
33222	Revision or relocation of skin pocket for pacemaker	123.00	90	3.0+T
33223	Revision of skin pocket for single of dual chamber pacing cardioverter defibrillator	140.00	90	3.0+T
33224	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion and/or replacement of generator)	143.00	90	3.0+T
33225	Insertion of pacing electrode, cardiac venous system, for left ventrical pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system) (List separately in addition to primary procedure) (Use 33225 in conjunction with 33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33222, 33233, 33234, 33235, 33240, 33249)	127.00	90	3.0+T
33226	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of generator)	138.00	90	3.0+T
33233	Removal of permanent pacemaker pulse generator	60.00	90	3.0+T
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	101.00	90	3.0+T
33235	dual lead system	123.00	90	3.0+T
33236	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular	177.00	90	3.0+T
33237	dual lead system	258.00	90	3.0+T
33238	Removal of permanent transvenous electrode(s) by thoracotomy	287.00	90	3.0+T
33240	Insertion single or dual chamber pacing of cardioverter-defibrillator pulse generator	146.00	90	3.0+T
33241	Subcutaneous removal of single or dual chamber pacing cardioverter-defibrillator pulse generator	57.00	90	3.0+T
	(For removal of electrode(s) by thoracotomy, use 33243 in conjunction with code 33241) (For removal of electrode(s) by transvenous extraction, use 33244 in conjunction with code 33241) (For removal and reinsertion of a pacing cardioverter-defibrillator system (pulse generator and electrodes), report 33241 and 33243 or 33244 and 33249)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
33243	Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by thoracotomy	348.00	90	15.0+T
33244	by transverse extraction	205.00	90	3.0+T
33245	Insertion of epicardial single or dual chamber pacing cardioverter-defibrillator electrodes by thoracotomy;	337.00	90	15.0+T
33246	with insertion of pulse generator	450.00	90	15.0+T
33249	Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator	379.00	90	3.0+T
	(For removal and reinsertion of a pacing cardioverter-defibrillator system (pulse generator and electrodes), report 33241 and 33243 or 33244 and 33249)			

ELECTROPHYSIOLOGIC OPERATIVE PROCEDURES

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	347.00	90	15.0+T
33251	with cardiopulmonary bypass	459.00	90	15.0+T
33253	Operative incisions and reconstruction of atria for treatment of atrial fibrillation or atrial flutter (eg, maze procedure)	603.00	90	15.0+T
33261	Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass	427.00	90	15.0+T

PATIENT-ACTIVATED EVENT RECORDER

33282	Implantation of patient-activated cardiac event recorder	108.00	90	3.0+T
	(Initial implantation includes programming) (For subsequent electronic analysis and/or reprogramming, use 93727)			
33284	Removal of an implantable, patient-activated cardiac event recorder	84.00	90	3.0+T

WOUNDS OF THE HEART AND GREAT VESSELS

33300	Repair of cardiac wound; without bypass	400.00	90	15.0+T
33305	with cardiopulmonary bypass	450.00	90	15.0+T
33310	Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); without bypass	400.00	90	15.0+T
33315	with cardiopulmonary bypass	450.00	90	15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
33320	Suture repair of aorta or great vessels; without shunt or cardiopulmonary bypass	240.00	60	12.0+T
33321	with shunt bypass	450.00	60	12.0+T
33322	with cardiopulmonary bypass	450.00	60	12.0+T
33330	Insertion of graft, aorta or great vessels; without shunt, or cardiopulmonary bypass	800.00	90	15.0+T
33332	with shunt bypass	BR	90	15.0+T
33335	with cardiopulmonary bypass	550.00	90	15.0+T

CARDIAC VALVES

AORTIC VALVE

33400	Valvuloplasty, aortic valve; open, with cardiopulmonary bypass	800.00	90	15.0+T
33401	open, with inflow occlusion	456.00	90	15.0+T
33403	using transventricular dilation, with cardiopulmonary bypass	BR	90	15.0+T
	(Do not report modifier –63 in conjunction with 33401, 33403)			
33404	Construction of apical-aortic conduit	800.00	90	15.0+T
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	800.00	90	15.0+T
33406	with allograft valve (freehand)	800.00	90	15.0+T
33410	with stentless tissue valve	BR		15.0+T
33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp	800.00	90	15.0+T
33412	with transventricular aortic annulus enlargement (Konno procedure)	950.00	90	15.0+T
33413	by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	950.00	90	15.0+T
33414	Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract	800.00		15.0+T
33415	Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis	300.00	90	15.0+T
33416	Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hyertrophy)	700.00		15.0+T
33417	Aortoplasty (gusset) for supravalvular stenosis	600.00	90	15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	MITRAL VALVE			
33420	Valvotomy, mitral valve; closed heart	560.00	90	15.0+T
33422	open heart, with cardiopulmonary bypass	720.00	90	15.0+T
33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass;	800.00	90	15.0+T
33426	with prosthetic ring	800.00	90	15.0+T
33427	radical reconstruction, with or without ring	800.00	90	15.0+T
33430	Replacement, mitral valve, with cardiopulmonary bypass	800.00	90	15.0+T
	TRICUSPID VALVE			
33460	Valvectomy, tricuspid valve, with cardiopulmonary bypass;	600.00	90	15.0+T
33463	Valvuloplasty, tricuspid valve; without ring insertion	650.00	90	15.0+T
33464	with ring insertion	675.00	90	15.0+T
33465	Replacement, tricuspid valve, with cardiopulmonary bypass	700.00	90	15.0+T
33468	Tricuspid valve repositioning and plication for Ebstein anomaly	800.00	90	15.0+T
	PULMONARY VALVE			
	(To report percutaneous valvuloplasty of pulmonary valve, see 92990)			
	(Do not report modifier –63 in conjunction with 33470, 33472)			
33470	Valvotomy, pulmonary valve, closed heart; transventricular	600.00	90	15.0+T
33471	via pulmonary artery	800.00	90	15.0+T
33472	Valvotomy, pulmonary valve, open heart; with inflow occlusion	800.00	90	15.0+T
33474	with cardiopulmonary bypass	800.00	90	15.0+T
33475	Replacement, pulmonary valve	900.00	90	15.0+T
33476	Right ventricular resection for infundibular stenosis, with or without commissurotomy	800.00	90	15.0+T
33478	Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection	800.00	90	15.0+T
	OTHER VALVULAR PROCEDURES			
33496	Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure) (For reoperation, use 33530 in addition to 33496)	800.00	90	15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	CORONARY ARTERY ANOMALIES			
	Basic procedures include endarterectomy or angioplasty. Do not report modifier –63 in conjunction with 33502-33506			
33500	Repair of coronary arteriovenous or arteriocardiac chamber fistula; with cardio-pulmonary bypass	875.00	90	15.0+T
33501	without cardio-pulmonary bypass	BR	90	15.0+T
33502	Repair of anomalous coronary artery from pulmonary artery origin; by ligation	BR	90	15.0+T
33503	by graft, without cardiopulmonary bypass	800.00	90	15.0+T
33504	by graft, with cardiopulmonary bypass	800.00	90	15.0+T
33505	with construction of intrapulmonary artery tunnel (Takeuchi procedure)	900.00	90	15.0+T
33506	by translocation from pulmonary artery to aorta	800.00	90	15.0+T
33507	Repair of anomalous (eg, intramural) aortic origin of coronary artery by unroofing or translocation	698.00	90	15+T
	ENDOSCOPY			
	Surgical vascular endoscopy always inlcudes diagnostic endoscopy.			
33508	Endoscopy, surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure (List separately in addition to primary procedure) (Use 35508 in conjunction with code 33510-33523) (For open harvest of upper extremity vein procedure, use 35500)	5.00		
	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	910.00	90	15.0+T
33511	two coronary venous grafts	1,130.00	90	15.0+T
33512	three coronary venous grafts	1,200.00	90	15.0+T
33513	four coronary venous grafts	1,252.00	90	15.0+T
33514	five coronary venous grafts	1,296.00	90	15.0+T
33516	six or more coronary venous grafts	1,335.00	90	15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

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 code for arterial graft)	97.00
33518	two venous grafts (List separately in addition to code for arterial graft)	187.00
33519	three venous grafts (List separately in addition to code for arterial graft)	233.00
33521	four venous grafts (List separately in addition to code for arterial graft)	266.00
33522	five venous grafts (List separately in addition to code for arterial graft)	284.00
33523	six or more venous grafts (List separately in addition to code for arterial graft)	332.00
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 only for codes 33400-33496; 33510-33536, 33863)	363.00

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

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	1,072.00	90	15.0+T
33534	two coronary arterial grafts	1,269.00	90	15.0+T
33535	three coronary arterial grafts	1,376.00	90	15.0+T
33536	four or more coronary arterial grafts	1,482.00	90	15.0+T
33542	Myocardial resection (eg, ventricular aneurysmectomy)	800.00	90	15.0+T
33545	Repair of postinfarction ventricular septal defect, with or without myocardial resection	720.00	90	15.0+T
33548	Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, DOR procedures)	785.00	90	15.0+T

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 only with 33510-33516, 33533-33536)	89.00		

SINGLE VENTRICLE AND OTHER COMPLEX CARDIAC ANOMALIES

33600	Closure of atrioventricular valve (mitral or tricuspid) by suture or patch	900.00	90	15.0+T
33602	Closure of semilunar valve (aortic or pulmonary) by suture or patch	900.00	90	15.0+T
33606	Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure)	900.00	90	15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
33608	Repair of complex cardiac anomaly other than pulmonary atresia with ventricular septal defect by construction or replacement of conduit from right or left ventricle to pulmonary artery (For repair of pulmonary atresia with ventricular septal defect, see 33918 - 33920) (Do not report modifier –63 in conjunction with 33610, 33611 or 33619)	900.00	90	15.0+T
33610	Repair of complex cardiac anomalies (eg, single ventricle with subaortic obstruction) by surgical enlargement of ventricular septal defect	900.00	90	15.0+T
33611	Repair of double outlet right ventricle with intraventricular tunnel repair;	1,000.00	90	15.0+T
33612	with repair of right ventricular outflow tract obstruction	1,000.00	90	15.0+T
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)	1,000.00	90	15.0+T
33617	Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure	1,000.00	90	15.0+T
33619	Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure) (Do not report modifier -63 in conjunction with 33619)	1,200.00	90	15.0+T

SEPTAL DEFECT

33641	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	800.00	90	15.0+T
33645	Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage	800.00	90	15.0+T
33647	Repair of atrial septal defect and ventricular septal defect, with direct or patch closure (Do not report modifier -63 in conjunction with 33647)	800.00	90	15.0+T
33660	Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair	800.00	90	15.0+T
33665	Repair of intermediate or transitional atrioventricular canal, with or without atrioventricular valve repair	800.00	90	15.0+T
33670	Repair of complete atrioventricular canal, with or without prosthetic valve (Do not report modifier –63 in conjunction with 33670)	800.00	90	15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
33681	Closure ventricular septal defect, with or without patch	720.00	90	15.0+T
33684	with pulmonary valvotomy or infundibular resection (acyanotic)	800.00	90	15.0+T
33688	with removal of pulmonary artery band, with or without gusset	800.00	90	15.0+T
33690	Banding of pulmonary artery (Do not report modifier –63 in conjunction with 33690)	400.00	90	13.0+T
33692	Complete repair tetralogy of Fallot without pulmonary atresia;	800.00	90	15.0+T
33694	with transannular patch (Do not report modifier –63 in conjunction with 33694)	800.00	90	15.0+T
33697	Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect	900.00	90	15.0+T
	SINUS OF VALSALVA			
33702	Repair sinus of Valsalva fistula, with cardiopulmonary bypass;	800.00	90	15.0+T
33710	with repair of ventricular septal defect	1,160.00	90	15.0+T
33720	Repair sinus of Valsalva aneurysm, with cardiopulmonary bypass	800.00	90	15.0+T
33722	Closure of aortico-left ventricular tunnel	BR	90	15.0+T
	TOTAL ANOMALOUS PULMONARY VENOUS DRAINAGE			
33730	Complete repair of anomalous venous return (supracardiac, intracardiac, or infracardic types) (For partial anomalous return, see atrial septal defect)	800.00	90	15.0+T
33732	Repair of cor triatriatum or supravalvular mitral ring by resection of left atrial membrane (Do not report modifier –63 in conjunction with 33730, 33732)	800.00	90	15.0+T
	SHUNTING PROCEDURES			
	(Do not report modifier –63 in conjunction with 33735, 33736, 33750, 33755, 33762)			
33735	Atrial septectomy or septostomy; closed heart (Blalock-Hanlon type operation)	600.00	90	15.0+T
33736	open heart with cardiopulmonary bypass	406.00	90	15.0+T
33737	open heart, with inflow occlusion	BR		15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
33750	Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation)	480.00	90	15.0+T
33755	ascending aorta to pulmonary artery (Waterston type operation)	BR		15.0+T
33762	descending aorta to pulmonary artery (Potts-Smith type operation)	600.00	90	15.0+T
33764	central, with prosthetic graft	600.00	90	15.0+T
33766	superior vena cava to pulmonary artery for flow to one lung (classical Glenn procedure)	600.00	90	15.0+T
33767	superior vena cava to pulmonary artery for flow to both lungs (bidirectional Glenn procedure)	700.00	90	15.0+T
33768	Anastomosis, cavopulmonary, second superior vena cava (List separately in addition to primary procedure)	207.00		
	TRANSPOSITION OF THE GREAT VESSELS			
33770	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect	800.00	90	15.0+T
33771	with surgical enlargement of ventricular septal defect	1000.00	90	15.0+T
33774	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass;	600.00	90	15.0+T
33775	with removal of pulmonary band	600.00	90	15.0+T
33776	with closure of ventricular septal defect	1,020.00	90	15.0+T
33777	with repair of subpulmonic obstruction	1,020.00	90	15.0+T
33778	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type) (Do not report modifier –63 in conjunction with 33778)	600.00	90	15.0+T
33779	with removal of pulmonary band	600.00	90	15.0+T
33780	with closure of ventricular septal defect	1,020.00	90	15.0+T
33781	with repair of subpulmonic obstruction	1,020.00	90	15.0+T
	TRUNCUS ARTERIOSUS			
33786	Total repair, truncus arteriosus (Rastelli type operation) (Do not report modifier –63 in conjunction with 33786)	850.00	90	15.0+T
33788	Reimplantation of an anomalous pulmonarY artery	650.00	90	15.0+T
	(For pulmonary artery band, see 33690)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	AORTIC ANOMALIES			
33800	Aortic suspension (aortopexy) for tracheal decompression (eg, for tracheomalacia) (separate procedure)	400.00	90	15.0+T
33802	Division of aberrant vessel (vascular ring);	480.00	90	15.0+T
33803	with reanastomosis	BR	90	15.0+T
33813	Obliteration of aortopulmonary septal defect; without cardiopulmonary bypass	600.00	90	15.0+T
33814	with cardiopulmonary bypass	600.00	90	15.0+T
33820	Repair of patent ductus arteriosus; by ligation	400.00	90	15.0+T
33822	by division, under 18 years	400.00	90	15.0+T
33824	by division, 18 years and older	400.00	90	15.0+T
33840	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis	600.00	90	15.0+T
33845	with graft	600.00	90	15.0+T
33851	repair using either left subclavian artery or prosthetic material as gusset for enlargement	600.00	90	15.0+T
33852	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass	600.00	90	15.0+T
33853	with cardiopulmonary bypass	800.00	90	15.0+T
	THORACIC AORTIC ANEURYSM			
33860	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension;	800.00	90	15.0+T
33861	with coronary reconstruction	800.00	90	15.0+T
33863	with aortic root replacement using composite prosthesis and coronary reconstruction	800.00	90	15.0+T
33870	Transverse arch graft, with cardiopulmonary bypass	900.00	90	15.0+T
33875	Descending thoracic aorta graft, with or without bypass	725.00	90	15.0+T
33877	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	950.00	90	15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	ENDOVASCULAR REPAIR OF DESCENDING THORACIC AORTA			
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	686.00	90	15.0+T
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	589.00	90	15.0+T
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	436.00	90	15.0+T
33884	each additional proximal extension (List separately in addition to primary procedure)	162.00		
33886	Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta	376.00	90	15.0+T
33889	Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral	325.00		15.0+T
33891	Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision	414.00		15.0+T
	PULMONARY ARTERY			
33910	Pulmonary artery embolectomy; with cardiopulmonary bypass	480.00	60	15.0+T
33915	without cardiopulmonary bypass	320.00	60	6.0+T
33916	Pulmonary endarterectomy with or without embolectomy, with cardiopulmonary bypass	520.00	90	15.0+T
33917	Repair of pulmonary artery stenosis by reconstruction with patch or graft	550.00	90	15.0+T
33920	Repair of pulmonary atresia with ventricular septal defect, by construction or replacement of conduit from right or left ventricle to pulmonary artery	625.00	90	15.0+T
	(For repair of other complex cardiac anomalies by construction or replacement of right or left ventricle to pulmonary artery conduit, see 33608)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
33922	Transection of pulmonary artery with cardiopulmonary bypass (Do not report modifier –63 in conjunction with 33922)	456.00	90	15.0+T
33924	Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to primary procedure) (Use 33924 only with 33470-33475, 33600-33619, 33684-33688, 33692-33697, 33735-33767, 33770-33781, 33786, 33918-33922)	111.00		
33925	Repair of pulmonary artery arborization anomalies by unifocalization; without cardiopulmonary bypass	BR	90	15.0+T
33926	with cardiopulmonary bypass (Do not report 33925, 33926 in conjunction with 33697)	665.00	90	15.0+T
HEART/LUNG TRANSPLANTATION				
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy	2000.00	90	15.0+T
33945	Heart transplant, with or without recipient cardiectomy	1600.00	90	15.0+T
CARDIAC ASSIST				
33960	Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial 24 hours	290.00		15.0+T
33961	each additional 24 hours	200.00		
	(Do not report 33960, 33961 in conjunction with global neonatal and pediatric critical care codes 99293-99296) (Do not report modifier –63 in conjunction with 33960, 33961) (For insertion of cannula for prolonged extracorporeal circulation, use 36822)			
33967	Insertion of intra-aortic balloon assist device, percutaneous	77.00		
33968	Removal of intra-aortic balloon assist device, percutaneous	11.00		
	(For percutaneous insertion, use 93536)			
33970	Insertion of intra-aortic balloon assist device through the femoral artery, open approach	300.00	30	15.0+T
33971	Removal of intra-aortic ballon assist device including repair of femoral artery, with or without graft	210.00	30	15.0+T
33973	Insertion of intra-aortic balloon assist device through the ascending aorta	199.00		15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
33974	Removal of intra-aortic balloon assist device from the ascending aorta, including repair of the ascending aorta, with or without graft	208.00	90	15.0+T
33975	Insertion of ventricular assist device; extracorporeal, single ventricle	397.00	90	15.0+T
33976	extracorporeal, biventricular	410.00	90	15.0+T
33977	Removal of ventricular assist device; extracorporeal, single ventricle	347.00	90	15.0+T
33978	extracorporeal, biventricular	397.00	90	15.0+T
33979	Insertion of ventricular assist device, implantable intracorporeal, single ventricle	500.00	90	15.0+T
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	BR	90	15.0+T
33999	Unlisted procedure, cardiac surgery	BR		15.0+T

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.

EMBOLECTOMY/THROMBECTOMY

ARTERIAL, WITH OR WITHOUT CATHETER

34001	Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision	240.00	60	6.0+T
34051	innominate, subclavian artery, by thoracic incision	320.00	60	6.0+T
34101	axillary, brachial, innominate, subclavian artery, by arm incision	240.00	60	5.0+T
34111	radial or u1nar artery, by arm incision	240.00	60	5.0+T
34151	renal, celiac, mesentery, aortoiliac artery, by abdominal incision	320.00	60	6.0+T
34201	femoropopliteal, aortoiliac artery, by leg incision	240.00	60	5.0+T
34203	popliteal-tibio-peroneal, by leg incision	240.00	60	5.0+T

VENOUS, DIRECT OR WITH CATHETER

34401	Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision	280.00	60	5.0+T
34421	vena cava, iliac, femoropopliteal vein, by leg incision	180.00	60	4.0+T
34451	vena cava, iliac, femoropopliteal vein, by abdominal and leg incision	280.00	60	5.0+T
34471	subclavian vein, by neck incision	180.00	60	4.0+T
34490	axillary and subclavian vein, by arm incision	180.00	60	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	VENOUS RECONSTRUCTION			
34501	Valvuloplasty, femoral vein	80.00	30	4.0+T
34502	Reconstruction of vena cava, any method	300.00	90	15.0+T
34510	Venous valve transposition, any vein donor	150.00	90	4.0+T
34520	Cross-over vein graft to venous system	150.00	90	4.0+T
34530	Saphenopopliteal vein anastomosis	200.00	90	4.0+T
	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).			
	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	375.00	90	15.0+T
34802	using modular bifurcated prosthesis (one docking limb)	375.00	90	15.0+T
34803	using modular bifurcated prosthesis (two docking limbs)	375.00	90	15.0+T
34804	using unibody bifurcated prosthesis	375.00	90	15.0+T
34805	using aorto-uniiliac or aorto-unifemoral prosthesis	375.00	90	15.0+T
34808	Endovascular placement of iliac artery occlusion device (List separately in addition to primary procedure) (Use 34808 in conjunction with codes 34800, 34813, 34825, 34826) (For radiological supervision and interpretation use 75952 in conjunction with 34800, 34802, 34804, 34808) (For open approach, report codes 34812-34820 in addition to codes 34800, 34802, 34804, 34808 as appropriate)	65.00	90	15.0+T
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (For bilateral procedure, use modifier -50)	105.00	90	15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
34813	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to primary procedure) (Use 34813 in conjunction with code 34812) (For femoral artery grafting, see 35521, 35533, 35546, 35551-35558, 35566, 35621, 35646, 35651-35661, 35666, 35700)	75.00	90	15.0+T
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)	150.00	90	15.0+T
34825	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel	200.00	90	15.0+T
34826	each additional vessel (List separately in addition to primary procedure) (Use 34826 in conjunction with code 34825)	65.00	90	
	(Use 34825, 34826 in addition to codes 34800-34808, 34900 as appropriate) (For radiological supervision and interpretation, use 75953)			
34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	530.00	90	15.0+T
34831	aorto-bi-iliac prosthesis	575.00	90	15.0+T
34832	aorto-bifemoral prosthesis	575.00	90	15.0+T
34833	Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral (Do not report 34833 in addition to 34820)	BR	90	15.0+T
34834	Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis by arm incision, unilateral	BR	90	15.0+T

ENDOVASCULAR RREPAIR OF ILIAC ANEURYSM

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

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

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

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

34900	Endovascular graft replacement for repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) (For bilateral procedure, use modifier –50) (For radiological supervision and interpretation, use 75954) (For placement of extension prothesis during endovascular iliac artery repair, use 34825)	BR		15.0+T

DIRECT REPAIR OF ANEURYSM OR EXCISION (PARTIAL OR TOTAL) AND GRAFT INSERTION FOR ANEURSYM, FALSE ANEURYSM, RUPTURED ANEURYSM, OR OCCLUSIVE DISEASE

(Procedures 35001 - 35162 include preparation of artery for anastomosis including endarterectomy)

(For direct repairs associated with occlusive disease only, see 35201-35286)

(For intracranial aneurysm, see 61700 et seq)

(For thoracic aortic aneurysm, see 33860-33875)

(For endovascular repair of abdominal aortic aneurysm, see 34800-34826)

(For endovascular repair of iliac artery aneurysm, see 34900)

35001	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, cartoid, subclavian artery, by neck incision	600.00	90	15.0+T
35002	for ruptured aneurysm, carotid, subclavian artery, by neck incision	BR		15.0+T
35005	for aneurysm, pseudoaneurysm, and associated occlusive disease, vertebral artery	600.00	90	15.0+T
35011	for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision	300.00	90	15.0+T
35013	for ruptured aneurysm, axillary- brachial artery, by arm incision	600.00	90	15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
35021	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, innominate, subclavian artery, by thoracic incision	600.00	90	15.0+T
35022	for ruptured aneurysm, innominate, subclavian artery, by thoracic incision	600.00	90	15.0+T
35045	for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery	600.00	90	15.0+T
35081	for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta	600.00	90	13.0+T
35082	for ruptured aneurysm, abdominal aorta	600.00	90	13.0+T
35091	for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)	600.00	90	13.0+T
35092	for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)	600.00	90	13.0+T
35102	for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)	600.00	90	13.0+T
35103	Direct repair of aneurysm, pseudoaneurysm or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)	600.00	90	13.0+T
35111	for aneurysm, pseudoaneurysm, and associated occlusive disease, splenic artery	600.00	90	15.0+T
35112	for ruptured aneurysm, splenic artery	600.00	90	15.0+T
35121	for aneurysm, pseudoaneurysm, and associated occlusive disease, heptic,celiac, renal or mesenteric artery	600.00	90	15.0+T
35122	for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery	600.00	90	15.0+T
35131	for aneurysm, pseudoaneurysm, and associated occlusive disease, iliac artery(common, hypogastric, external)	600.00	90	13.0+T
35132	for ruptured aneurysm, iliac artery (common, hypogastric, external)	600.00	90	13.0+T
35141	for aneurysm, pseudoaneurysm, and associated occulsive disease, common femoral artery (profunda femoris, superficial femoral)	480.00	90	5.0+T
35142	for ruptured aneurysm, common femoral artery (profunda femoris,superficial femoral)	480.00	90	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
35151	Direct repair of aneurysm, pseudoaneurysm or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery	480.00	90	5.0+T
35152	for ruptured aneurysm, popliteal artery	480.00	90	5.0+T

REPAIR ARTERIOVENOUS FISTULA

35180	Repair, congenital arteriovenous fistula; head and neck	250.00	90	5.0+T
35182	thorax and abdomen	BR		5.0+T
35184	extremities	BR		3.0+T
35188	Repair, acquired or traumatic arteriovenous fistula; head and neck	260.00	90	5.0+T
35189	thorax and abdomen	BR		5.0+T
35190	extremities	230.00	90	3.0+T

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

(For AV fistula repair, see 35180-35190)

35201	Repair blood vessels, direct; neck	200.00	90	3.0+T
35206	upper extremity	200.00	90	3.0+T
35207	hand, finger	220.00	90	3.0+T
35211	intrathoracic, with bypass	450.00	90	5.0+T
35216	intrathoracic, without bypass	365.00	90	3.0+T
35221	intra-abdominal	285.00	90	5.0+T
35226	lower extremity	190.00	90	3.0+T
35231	Repair blood vessel with vein graft; neck	220.00	90	3.0+T
35236	upper extremity	220.00	90	3.0+T
35241	intrathoracic, with bypass	465.00	90	5.0+T
35246	intrathoracic, without bypass	400.00	90	5.0+T
35251	intra-abdominal	300.00	90	5.0+T
35256	lower extremity	375.00	90	3.0+T
35261	Repair blood vessel with graft other than vein; neck	220.00	90	3.0+T
35266	upper extremity	220.00	90	3.0+T
35271	intrathoracic, with bypass	435.00	90	5.0+T
35276	intrathoracic, without bypass	380.00	90	5.0+T
35281	intra-abdominal	310.00	90	3.0+T
35286	lower extremity	250.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	THROMBOENDARTERECTOMY			
	(For coronary artery, see 33510-33536 and 33572)			
35301	Thromboendarterectomy, with or without patch graft; carotid, vertebral,subclavian, by neck incision	480.00	90	6.0+T
35311	subclavian, innominate, by thoracic incision	600.00	90	6.0+T
35321	axillary-brachial	350.00	90	6.0+T
35331	abdominal aorta	600.00	90	13.0+T
35341	mesenteric, celiac, or renal	600.00	90	15.0+T
35351	iliac	600.00	90	13.0+T
35355	iliofemoral	600.00	90	13.0+T
35361	combined aortoiliac	600.00	90	13.0+T
35363	combined aortoiliofemoral	600.00	90	13.0+T
35371	common femoral	300.00	90	15.0+T
35372	deep (profunda) femoral	300.00	90	15.0+T
35381	femoral and/or popliteal, and/or tibioperoneal	480.00	90	5.0+T
35390	Reoperation, carotid, thromboendarterectomy, more than one month after original operation (List separately in addition to primary procedure) (Use 35390 only with 35301)	57.00		6.0+T
	ANGIOSCOPY			
35400	Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (List separately in addition to code for primary procedure)	51.00		
	TRANSLUMINAL ANGIOPLASTY			
	(For radiological supervision and interpretation, see 75962-75968, 75978)			
	OPEN			
35450	Transluminal balloon angioplasty, open; renal or other visceral artery	180.00	90	3.0+T
35452	aortic	120.00	90	3.0+T
35454	iliac	120.00	90	3.0+T
35456	femoral-popliteal	135.00	90	3.0+T
35458	brachiocephalic trunk or branches, each vessel	160.00	90	3.0+T
35459	tibioperoneal trunk and branches	160.00	90	3.0+T
35460	venous	110.00	90	3.0+T
	(For coronary artery procedure, see 92982, 92984) (For catheter placement procedure, see 93510)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

PERCUTANEOUS

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

35470	Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel	160.00	90	3.0+T
35471	renal or visceral artery	180.00	90	3.0+T
35472	aortic	120.00	90	3.0+T
35473	iliac	115.00	90	3.0+T
35474	femoral-popliteal	135.00	90	3.0+T
35475	brachiocephalic trunk or branches, each vessel	170.00	90	3.0+T
35476	venous	100.00	90	3.0+T

(For radiological supervision and interpretation, see 75978)

TRANSLUMINAL ATHERECTOMY

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

OPEN

35480	Transluminal peripheral atherectomy, open; renal or other visceral artery	190.00	90	3.0+T
35481	aortic	160.00	90	3.0+T
35482	iliac	150.00	90	3.0+T
35483	femoral-popliteal	165.00	90	3.0+T
35484	brachiocephalic trunk or branches, each vessel	190.00	90	3.0+T
35485	tibioperoneal trunk and branches	180.00	90	3.0+T

PERCUTANEOUS

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

35490	Transluminal peripheral atherectomy, percutaneous; renal or other visceral artery	200.00	90	3.0+T
35491	aortic	130.00	90	3.0+T
35492	iliac	130.00	90	3.0+T
35493	femoral-popliteal	150.00	90	3.0+T
35494	brachiocephalic trunk or branches, each vessel	180.00	90	3.0+T
35495	tibioperoneal trunk and branches	160.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

BYPASS GRAFT

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.

VEIN

35500	Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure (List separately in addition to primary procedure) (For harvest of more than one vein segment, see 35682, 35683) (For endoscopic procedure, use 33508)	99.00	90	
35501	Bypass graft, with vein; carotid	480.00	90	5.0+T
35506	carotid-subclavian	480.00	90	5.0+T
35507	subclavian-carotid	480.00	90	5.0+T
35508	carotid-vertebral	480.00	90	5.0+T
35509	carotid-carotid	480.00	90	5.0+T
35510	carotid-brachial	480.00	90	5.0+T
35511	subclavian-subclavian	480.00	90	5.0+T
35512	subclavian-brachial	480.00	90	5.0+T
35515	subclavian-vertebral	480.00	90	5.0+T
35516	subclavian-axillary	480.00	90	5.0+T
35518	axillary-axillary	480.00	90	5.0+T
35521	axillary-femoral	480.00	90	5.0+T
35522	axillary-brachial	480.00	90	5.0+T
35525	brachial-brachial	480.00	90	5.0+T
35526	aortosubclavian or carotid	600.00	90	15.0+T
35531	aortoceliac or aortomesenteric	600.00	90	15.0+T
35533	axillary-femoral-femoral	480.00	90	15.0+T
35536	splenorenal	400.00	90	9.0+T
35541	aortoiliac or bi-iliac	600.00	90	13.0+T
35546	aortofemoral or bifemoral	600.00	90	13.0+T
35548	aortoiliofemoral, unilateral	600.00	90	13.0+T
35549	aortoiliofemoral, bilateral	900.00	90	13.0+T
35551	aortofemoral-popliteal	840.00	90	13.0+T
35556	femoral-popliteal	480.00	90	5.0+T
35558	femoral-femoral	480.00	90	5.0+T
35560	aortorenal	400.00	90	9.0+T
35563	ilioiliac	480.00	90	5.0+T
35565	iliofemoral	480.00	90	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
35566	Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels	480.00	90	5.0+T
35571	popliteal-tibial, -peroneal artery or other distal vessels	480.00	90	5.0+T
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 cojnuction with code 33510-33516, 33517-33523, 34502, 34520, 35001-35002, 35011-35022, 35102-35103, 35121-35152, 35231-35256, 35501-35587, 35879-35881, 35901-35907)	108.00	90	
	IN-SITU VEIN			
35583	In-situ vein bypass; femoral-popliteal	480.00	90	5.0+T
35585	femoral-anterior tibial, posterior tibial, or peroneal artery	480.00	90	5.0+T
35587	popliteal-tibial, peroneal	480.00	90	5.0+T
	OTHER THAN VEIN			
35600	Harvest of upper extremity artery, one segment, for coronary artery bypass procedure	80.00		
35601	Bypass graft, with other than vein; carotid	480.00	90	5.0+T
35606	carotid-subclavian	480.00	90	5.0+T
35612	subclavian-subclavian	480.00	90	5.0+T
35616	subclavian-axillary	480.00	90	5.0+T
35621	axillary-femoral	480.00	90	5.0+T
35623	axillary-popliteal or -tibial	276.00	90	5.0+T
35626	aortosubclavian or carotid	600.00	90	15.0+T
35631	aortoceliac, aortomesenteric, aortorenal	600.00	90	15.0+T
35636	splenorenal (splenic to renal arterial anastomosis)	400.00	90	9.0+T
35641	aortoiliac or bi-iliac	600.00	90	13.0+T
	(For open placement of aorto-bi-iliac prosthesis following unsuccessful endovascular repair, use 34831)			
35642	carotid-vertebral	480.00	90	5.0+T
35645	subclavian-vertebral	480.00	90	5.0+T
35646	aortobifemoral	600.00	90	13.0+T
	(For open placement of aortobifemoral prosthesis following unsuccessful endovascular repair, use 34832)			
35647	aortofemoral	462.00	90	13.0+T
35650	axillary-axillary	480.00	90	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
35651	Bypass graft, with other than vein; aortofemoral-popliteal	840.00	90	13.0+T
35654	axillary-femoral-femoral	480.00	90	5.0+T
35656	femoral-popliteal	480.00	90	5.0+T
35661	femoral-femoral	480.00	90	5.0+T
35663	ilioiliac	480.00	90	5.0+T
35665	iliofemoral	480.00	90	5.0+T
35666	femoral-anterior tibial, posterior tibial, or peroneal artery	480.00	90	5.0+T
35671	popliteal-tibial, or -peroneal artery	480.00	90	5.0+T

COMPOSITE GRAFTS

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

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

35681	Bypass graft; composite, prosthetic and vein (List separately in addition to primary procedure)	150.00	90	5.0+T
35682	autogenous composite, two segments of veins from two locations (List separately in addition to primary procedure)	220.00	90	
35683	autogenous composite, three or more segments of vein from two or more locations (List separately in addition to primary procedure)	250.00	90	

ADJUVANT TECHNIQUES

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

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

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

35685	Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to primary procedure) (Use 35685 in conjunction with codes 35656, 35666, or 35671)	64.00		

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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)	53.00		
	ARTERIAL TRANSPOSITION			
35691	Transposition and/or reimplantation; vertebral to carotid artery	436.00	90	5.0+T
35693	vertebral to subclavian artery	275.00	90	5.0+T
35694	subclavian to carotid artery	319.00	90	5.0+T
35695	carotid to subclavian artery	319.00	90	5.0+T
35697	Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery (List separately in addition to primary procedure)	48.00		5.0+T
	EXPLORATION/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)	55.00		5.0+T
35701	Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery	135.00	30	5.0+T
35721	femoral artery	135.00	30	5.0+T
35741	popliteal artery	135.00	30	5.0+T
35761	other vessels	135.00	30	5.0+T
35800	Exploration for postoperative hemorrhage, thrombosis or infection; neck	140.00	45	4.0+T
35820	chest	300.00	90	11.0+T
35840	abdomen	160.00	45	4.0+T
35860	extremity	135.00	45	4.0+T
35870	Repair of graft-enteric fistula	250.00	90	4.0+T
35875	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula);	206.00	90	4.0+T
35876	with revision of arterial or venous graft	247.00	90	4.0+T
	(For thrombectomy of hemodialysis graft or fistula, see 36831, 36833)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	(Codes 35879 and 35881 describe open revision of graft-threatening stenoses of lower extremity arterial bypass graft(s) (previously constructed with autogenous vein conduit) using vein patch angioplasty or segmental vein interposition techniques)			
	(For thrombectomy with revision of any non-coronary arterial or venous graft, including those of the lower extremity, (other than hemodialysis graft or fistula), use 35876)			
	(For direct repair (other than for fistula) of a lower extremity blood vessel (with or without patch angioplasty), use 35226)			
	(For repair (other than for fistula) of a lower extremity blood vessel using a vein graft, use 35256)			
35879	Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty	260.00	90	5.0+T
35881	with segmental vein interposition	270.00	90	5.0+T
35901	Excision of infected graft; neck	173.00	90	4.0+T
35903	extremity	188.00	90	4.0+T
35905	thorax	278.00	90	4.0+T
35907	abdomen	286.00	90	4.0+T

VASCULAR INJECTION PROCEDURES

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

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

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

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

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

(For chemotherapy of malignant disease, see 96400-96549)

INTRAVENOUS

36000	Introduction of needle or intracatheter, vein (for radiological vascular injection procedure not otherwise listed)	20.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
36002	Injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm	54.00		3.0+T
	(For imaging guidance, see 76003, 76360, 76393 or 76942) (For ultrasound guided compression repair of pseudoaneurysm, use 76936) (Do not report 36002 for vascular sealant of an arteriotomy site)			
36005	Injection procedure for extremity venography (including introduction of needle or intracatheter)	20.00		3.0+T
	(For radiological supervision and interpretation, use 75820, 75822)			
36010	Introduction of catheter; superior or inferior vena cava	37.00		3.0+T
36011	Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)	47.00		3.0+T
36012	second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)	52.00		3.0+T
36013	Introduction of catheter, right heart or main pulmonary artery	36.00		3.0+T
36014	Selective catheter placement, left or right pulmonary artery	45.00		3.0+T
36015	Selective catheter placement, segmental or subsegmental pulmonary artery	52.00		3.0+T
	(For insertion of flow directed catheter (eg, Swan-Ganz), see 93503) (For venous catheterization for selective organ blood sampling, see 36500)			
	INTRA-ARTERIAL - INTRA-AORTIC			
36100	Introduction of needle or intracatheter, carotid or vertebral artery	45.00		4.0+T
36120	Introduction of needle or intracatheter; retrograde brachial artery	30.00		3.0+T
36140	extremity artery	30.00		3.0+T
36145	arteriovenous shunt created for dialysis (cannula, fistula or graft)	200.00	21	3.0+T
	(For insertion of arteriovenous cannula, see 36810-36821)			
36160	Introduction of needle or intracatheter, aortic, translumbar	45.00		3.0+T
36200	Introduction of catheter, aorta	70.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
36215	Selective catheter placement, arterial system; each first order thoracic or bracheocephalic branch, within a vascular family	95.00		3.0+T
36216	initial second order thoracic or bracheocephalic branch, within a vascular family	115.00		3.0+T
36217	initial third order or more selective thoracic or bracheocephalic branch, within a vascular family	140.00		3.0+T
36218	additional second order, third order and beyond, thoracic or bracheocephalic branch, within a vascular family	25.00		

(Use in addition to code for initial second or third order vessel as appropriate) (Use 36218 in conjunction with codes 36216, 36217)

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

36245	Selective catheter placement, arterial system; each first order abdominal, pelvic or lower extremity artery branch, with a vascular family	105.00		3.0+T
36246	initial second order abdominal, pelvic or lower extremity artery branch, within a vascular family	115.00		3.0+T
36247	initial third order or more selective abdominal, pelvic or lower extremity artery branch, within a vascular family	140.00		3.0+T
36248	additional second order, third order and beyond, abdominal, pelvic or lower extremity artery branch, within a vascular family	25.00		
36260	Insertion of implantable intra-arterial infusion pump (eg, for chemotherapy of liver)	190.00	90	3.0+T
36261	Revision of implanted intra-arterial infusion pump	100.00	90	3.0+T
36262	Removal of implanted intra-arterial infusion pump	75.00	90	3.0+T
36299	Unlisted procedure, vascular injection	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	VENOUS			
	(Do not report modifier –63 in conjunction with 36420, 36450, 36460)			
36400	Venipuncture, under age 3 years, necessitating physician's skill, not to be used for routine venipuncture; femoral or jugular vein	8.00		3.0+T
36405	scalp vein	12.00		3.0+T
36406	other vein	8.00		3.0+T
36420	Venipuncture, cutdown; under age 1 year	16.00		3.0+T
36425	age 1 or over	12.00		3.0+T
36430	Transfusion, blood or blood components	8.00		3.0+T
36440	Push transfusion, blood, 2 years or under	20.00		3.0+T
36450	Exchange transfusion, blood; newborn	120.00	15	3.0+T
36455	other than newborn	100.00		3.0+T
36460	Transfusion, intrauterine, fetal	100.00	15	3.0+T
	(For radiological supervision and interpretation, see 76941)			
36468	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk	8.00	15	3.0+T
36469	face	8.00	15	3.0+T
36470	Injection of sclerosing solution; single vein	4.00		3.0+T
36471	multiple veins, same leg	8.00		3.0+T
36481	Percutaneous portal vein catheterization by any method	145.00		3.0+T
	(For radiological supervision and interpretation, see 75885, 75887)			
36500	Venous catheterization for selective organ blood sampling	50.00		3.0+T
	(For catheterization in superior or inferior vena cava, see 36010) (For radiological supervision and interpretation, see 75893)			
36510	Catheterization of umbilical vein for diagnosis or therapy, newborn	16.00		3.0+T
	(For codes 36511-36516 when performing professional component, see modifier –26.)			
36511	Therapeutic apheresis; for white blood cells	150.00		
36512	for red blood cells	150.00		
36513	for platelets	150.00		
36514	for plasma pheresis	150.00		
36515	with extracorporeal immunoadsorption and plasma reinfusion	150.00		
36516	with extracorporeal selective absorption or selective filtration and plasma reinfusion	150.00		

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
36522	Photopheresis, extracorporeal (For professional component, see modifier -26)	150.00		3.0+T
36540	Collection of blood specimen from a completely implantable venous access device	8.00		
36550	Declotting by thrombolytic agent of implanted vascular access device or catheter	8.00		
36555	Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age	160.00		3.0+T
36556	age 5 years or older	160.00		3.0+T
36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age	95.00	10	3.0+T
36558	age 5 years or older	93.00	10	3.0+T
36560	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; under 5 years of age	177.00	10	3.0+T
36561	age 5 years or older	176.00	10	3.0+T
36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	115.00	10	3.0+T
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)	141.00	10	3.0+T
36566	with subcutaneous port(s)	148.00	10	3.0+T
36568	Insertion of peripherally inserted central venous catheter (picc), without subcutaneous port or pump; under 5 years of age	112.00		3.0+T
36569	age 5 years or older	94.00		3.0+T
36570	Insertion of peripherally inserted central venous access device, with subcutaneous port; under 5 years of age	227.00	10	3.0+T
36571	age 5 years or older	204.00	10	3.0+T
36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	80.00		3.0+T
36576	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	80.00	10	3.0+T
36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	80.00	10	3.0+T
36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	79.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	101.00	10	3.0+T
36582	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access	101.00	10	3.0+T
36583	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access	101.00	10	3.0+T
36584	Replacement, complete, of a peripherally inserted central venous catheter (picc), without subcutaneous port or pump, through same venous access	80.00		3.0+T
36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access	101.00	10	3.0+T
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	47.00	10	3.0+T
36590	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion	58.00	10	3.0+T
36595	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access	402.00		3.0+T
36596	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen	91.00		3.0+T
36597	Repositioning of previously placed central venous catheter under fluoroscopic guidance	80.00		3.0+T
36598	Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report	75.00		3.0+T
ARTERIAL				
36600	Arterial puncture, withdrawal of blood for diagnosis (Do not report modifier-63 in conjunction with 36660)	7.50		3.0+T
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous	7.50		3.0+T
36625	cutdown	32.00		3.0+T
36640	Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown (see also 96420-96425)	32.00		3.0+T
	(For arterial catheterization for occlusion therapy, see 75894)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
36660	Catheterization, umbilical artery, newborn, for diagnosis or therapy (Do not report modifier –63 with 36660)	20.00	7	3.0+T
	INTRAOSSEOUS			
36680	Placement of needle for intraosseous infusion	25.00		3.0+T
	HEMODIALYSIS ACCESS, INTERVASCULAR CANNULIZATION FOR EXTRACORPOREAL CIRCULATION, OR SHUNT INSERTION			
36800	Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein	200.00	21	3.0+T
36810	arteriovenous, external (Scribner type)	200.00	21	3.0+T
36815	arteriovenous, external revision or closure	125.00	21	3.0+T
36818	Arteriovenous anastomosis, open; by upper arm cephalic vein transposition	209.00	90	3.0+T
36819	Arteriovenous anastomosis, open; by upper arm basilic vein transposition	241.00	21	3.0+T
36820	by forearm vein transposition	241.00	21	3.0+T
36821	direct, any site(eg. Cimino type) (separate procedure)	200.00	21	3.0+T
36822	Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure) (For maintenance of prolonged extracorporal circulation, use 33960, 33961)	220.00	21	3.0+T
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	376.00	21	3.0+T
36825	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft	200.00	21	3.0+T
36830	nonautogenous graft (eg, biological collogen, thermoplastic graft) (For direct arteriovenous anastomosis, use 36821)	400.00	60	6.0+T
36831	Thrombectomy, open, arteriovenous fistula without revision, autogenous or non-autogenous dialysis graft (separate procedure)	126.00	90	6.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
36832	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or non-autogenous dialysis graft (separate procedure)	179.00	21	4.0+T
36833	with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	179.00	21	4.0+T
36834	Plastic repair of arteriovenous aneurysm (separate procedure)	202.00	21	4.0+T
36835	Insertion of Thomas shunt (separate procedure)	116.00	21	3.0+T
36838	Distal revascularization and interval ligation (dril), upper extremity hemodialysis access (steal syndrome)	354.00	90	3.0+T
36860	External cannula declotting (separate procedure); without balloon catheter	8.00		3.0+T
36861	with balloon catheter	8.00		3.0+T
	(If imaging guidance is performed, use 76000)			
36870	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis) (Do not report 36550 in conjunction with code 36870) (For catheterization, use 36145) (For radiological supervision and interpretation, use 75790)	100.00	90	3.0+T

PORTAL DECOMPRESSION PROCEDURES

37140	Venous anastomosis, open; portocaval	400.00	90	9.0+T
	(For peritoneal-venous shunt, see 49425)			
37145	renoportal	400.00	90	9.0+T
37160	caval-mesenteric	400.00	90	9.0+T
37180	splenorenal, proximal	400.00	90	9.0+T
37181	splenorenal, distal (selective decompression of esophagogastric varices, any technique)	400.00	90	9.0+T
	(For percutaneous procedure, see 37182)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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 code 37182) (For open procedure, use 37140)	267.00	30	3.0+T
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)	124.00	30	3.0+T

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.

ARTERIAL MECHANICAL THROMBECTOMY

37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	190.00		3.0+T
37185	second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)	62.00		
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)	129.00		

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	VENOUS MECHANICAL THROMBECTOMY			
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	185.00		3.0+T
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	160.00		
	OTHER PROCEDURES			
37195	Thrombolysis, cerebral, by intravenous infusion	90.00		
37200	Transcatheter biopsy	70.00		3.0+T
	(For radiological supervision and interpretation, see 75970)			
37201	Transcatheter therapy, infusion for thrombolysis other than coronary	95.00		3.0+T
	(For radiological supervision and interpretation, see 75970)			
37201	Transcatheter therapy, infusion for thrombolysis other than coronary	95.00		3.0+T
37202	Transcatheter therapy, infusion other than for thrombolysis, any type (eg, spasmolytic, vasoconstrictive)	105.00		3.0+T
37201	Transcatheter therapy, infusion for thrombolysis other than coronary	95.00		3.0+T
37202	Transcatheter therapy, infusion other than for thrombolysis, any type (eg, spasmolytic, vasoconstrictive)	105.00		3.0+T
	(For 37201, 37202, for radiological supervision and interpretation, use 75896)			
	(For thromolysis of coronary vessels, see 92975, 92977)			
37203	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)	90.00		3.0+T
	(For radiological supervision and interpretation, see 75961)			
37204	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck (see also 61624, 61626)	300.00		3.0+T
	(For radiological supervision and interpretation, see 75894)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
37205	Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel	150.00		3.0+T
37206	each additional vessel	70.00		
37207	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; initial vessel	150.00		3.0+T
37208	each additional vessel	70.00		
	(For radiological supervision and interpretation, use 75960) (For catheterizations, see 36215-36248) (For transcatheter placement of intracoronary stent(s), see 92980, 92981)			
37209	Exchange of a previously placed intravascular catheter during thrombolytic therapy	40.00		3.0+T
	(For radiological supervision and interpretation, see 75900)			
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection	300.00	90	3.0+T
37216	without distal embolic protection	300.00	90	3.0+T

INTRAVASCULAR ULTRASOUND SERVICES

Intravascular ultrasound services include all transducer manipulations and repositioning within the specific vessel being examined, both before and after therapeutic intervention (eg, stent placement). Vascular access for intravascular ultrasound performed during a therapeutic intervention is not reported separately.

37250	Intrasvascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel	30.00		
37251	each additional vessel	23.00		
	(For catheterizations, see 36215-36248) (For transcatheter therapies, see 37200-37208, 61624, 61626) (For radiological supervision and interpretation see 75945, 75946)			

ENDOSCOPY

Surgical vascular endoscopy always includes diagnostic endoscopy.

37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	216.00		3.0+T
	(For open procedure, use 37760)			
37501	Unlisted vascular endoscopy procedure	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	LIGATION			
	(For ligation treatment of intracranial aneurysm, see 61703)			
	(For transcatheter permanent arterial occlusion or embolization, see 61624-61626)			
	(For endovascular temporary arterial balloon occlusion, use 61623)			
37565	Ligation, internal jugular vein	160.00	30	4.0+T
37600	Ligation; external carotid artery	160.00	30	4.0+T
37605	internal or common carotid artery	160.00	30	4.0+T
37606	internal or common carotid artery, with gradual occlusion, as witH Selverstone or Crutchfield clamp	80.00	30	4.0+T
37607	Ligation or banding of angioaccess arteriovenous fistula	104.00	90	4.0+T
37609	Ligation or biopsy, temporal artery	30.00	14	3.0+T
37615	Ligation, major artery (eg, post-traumatic, rupture); neck	160.00	30	4.0+T
37616	chest	300.00	90	11.0+T
37617	abdomen	270.00	30	4.0+T
37618	extremity	120.00	30	4.0+T
37620	Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular,intravascular (umbrella device)	240.00	90	5.0+T
	(For radiological supervision and interpretation, see 75940)			
37650	Ligation of femoral vein	100.00	30	3.0+T
37660	Ligation of common iliac vein	200.00	90	3.0+T
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	80.00	30	3.0+T
37718	Ligation, division and stripping, short saphenous vein	120.00	90	3.0+T
37722	Ligation, division and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	120.00	90	3.0+T
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	200.00	30	3.0+T
37760	Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open	200.00	30	3.0+T
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions	133.00	90	3.0+T
37766	more than 20 incisions	161.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	50.00	30	3.0+T
37785	Ligation, division, and/or excision of recurrent or secondary varicose veins (clusters), one leg	20.00	15	3.0+T

OTHER PROCEDURES

37788	Penile revascularization, artery, with or without vein graft	BR	30	3.0+T
37790	Penile venous occlusive procedure	132.00	90	3.0+T
37799	Unlisted procedure, vascular surgery	BR		3.0+T

HEMIC AND LYMPHATIC SYSTEMS

SPLEEN

EXCISION

38100	Splenectomy; total (separate procedure)	240.00	45	6.0+T
38101	partial	240.00	45	6.0+T
38102	total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure)	86.00		

REPAIR

38115	Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy	240.00	45	6.0+T

LAPAROSCOPY

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

38120	Laparoscopy, surgical, splenectomy	240.00	45	6.0+T
38129	Unlisted laparoscopy procedure, spleen	BR		6.0+T

INTRODUCTION

38200	Injection procedure for splenoportography	40.00	7	3.0+T

(For radiological supervision and interpretation, see 75810)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	GENERAL			
	BONE MARROW OR STEM CELL SERVICES/PROCEDURES			
38220	Bone marrow; aspiration only	62.00		3.0+T
38221	biopsy, needle or trocar	66.00		3.0+T
38230	Bone marrow harvesting for transplantation	78.00	10	3.0+T
38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic	48.00		3.0+T
38241	autologous	47.00		3.0+T
38242	allogeneic donor lymphocyte infusions	8.00		
	LYMPH NODES AND LYMPHATIC CHANNELS			
	INCISION			
38300	Drainage of lymph node abscess or lymphadenitis; simple	12.00		3.0+T
38305	extensive	20.00		3.0+T
	(If imaging guidance is performed, see 76360, 76393, 76942) (For fine needle aspiration, use 10021 or 10022)			
38308	Lymphangiotomy or other operations on lymphatic channels	60.00	90	3.0+T
38380	Suture and/or ligation of thoracic duct; cervical approach	300.00	90	12.0+T
38381	thoracic approach	300.00	90	12.0+T
38382	abdominal approach	300.00	90	12.0+T
	EXCISION			
38500	Biopsy or excision of lymph node(s); open, superficial (separate procedure) (Do not report 38500 with 38700-38780)	20.00	30	3.0+T
38505	by needle, superficial (eg, cervical, inguinal, axillary) (If imaging guidance is performed, see 76360, 76393, 76942) (For fine needle aspiration, use 10021, 10022)	20.00	30	3.0+T
38510	open, deep cervical node(s)	60.00	30	3.0+T
38520	open, deep cervical node(s) with excision scalene fat pad	110.00	30	3.0+T
38525	open, deep axillary node(s)	60.00	30	3.0+T
38530	open, internal mammary node(s) (separate procedure) (Do not report 38530 with 38720-38746)	120.00	30	3.0+T
	(For percutaneous needle biopsy, retroperitoneal lymph node or mass, see 49180) (For fine needle aspiration, use 10022)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
38542	Dissection, deep jugular node(s)	100.00	30	3.0+T
	(For radical cervical neck dissection, see 38720)			
38550	Excision of cystic hygroma, axillary or cervical; without deep neurovascular dissection	130.00	30	3.0+T
38555	with deep neurovascular dissection	275.00	30	3.0+T

LIMITED LYMPHADENECTOMY FOR STAGING

38562	Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic	320.00	60	3.0+T
38564	retroperitoneal (aortic and/or splenic)	400.00	90	5.0+T
	(When 38562 is combined with prostatectomy, use 55812 or 55842) (When 38562 is combined with insertion of radioactive substance into prostate, use 55862)			

LAPAROSCOPY

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

38570	Laparoscopy,surgical;with retroperitoneal lymph node sampling (biopsy), single or multiple	165.00	10	3.0+T
38571	with bilateral total pelvic Lymphadenectomy	211.00	10	3.0+T
38572	with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy) single or multiple	249.00	10	3.0+T
	(For drainage of lymphocele to peritoneal cavity, use 49323)			
38589	Unlisted laparoscopy procedure, lymphatic system	BR		3.0+T

RADICAL LYMPHADENECTOMY (RADICAL RESECTION OF LYMPH NODES)

(For limited pelvic and retroperitoneal lymphadenectomies, see 38562, 38564)

38700	Suprahyoid lymphadenectomy	200.00	60	4.0+T
38720	Cervical lymphadenectomy (complete)	320.00	60	4.0+T
38724	Cervical lymphadenectomy (modified radical neck dissection)	350.00	60	4.0+T
38740	Axillary lymphadenectomy; superficial	100.00	60	3.0+T
38745	complete	200.00	60	3.0+T
38746	Thoracic lymphadenectomy, regional, including mediastinal and peritracheal nodes (Report in addition to code for primary procedure)	78.00		

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
38747	Abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para-aortic and vena caval nodes (List separately in addition to primary procedure)	87.00		
38760	Inguinofemoral lymphadenectomy, superficial, including Cloquet's node (separate procedure)	200.00	60	3.0+T
38765	Inguinofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	320.00	60	3.0+T
38770	Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	320.00	60	3.0+T
38780	Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)	400.00	90	5.0+T
	(For excision and repair of lymphedematous skin and subcutaneous tissue, see 15000, 15570-15650)			
	INTRODUCTION			
38790	Injection procedure; lymphangiography	40.00	14	3.0+T
38792	for identification of sentinel node	40.00	14	3.0+T
	(For radiological supervision and interpretation, see 75801-75807) (For excision of sentinel node, see 38500-38542)			
38794	Cannulation, thoracic duct	BR	7	3.0+T
38999	Unlisted procedure, hemic or lymphatic system	BR		3.0+T

MEDIASTINUM AND DIAPHRAGM

MEDIASTINUM

INCISION

39000	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; cervical approach	160.00	90	12.0+T
39010	transthoracic approach, including either transthoracic or median sternotomy	320.00	90	12.0+T

EXCISION

39200	Excision of mediastinal cyst	200.00	90	12.0+T
39220	Excision of mediastinal tumor	400.00	90	12.0+T
	(For substernal thyroidectomy, see 60270; for thymectomy, see 60520)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	ENDOSCOPY			
39400	Mediastinoscopy, with or without biopsy	160.00	90	5.0+T
39499	Unlisted procedure, mediastinum	BR		3.0+T
	DIAPHRAGM			
	REPAIR			
39501	Repair, laceration of diaphragm, any approach	320.00	60	3.0+T
39502	Repair, paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, except neonatal	360.00	60	13.0+T
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)	360.00	60	13.0+T
39520	Repair, diaphragmatic hernia (esophageal hiatal); transthoracic	320.00	60	11.0+T
39530	combined, thoracoabdominal	320.00	60	11.0+T
39531	combined, thoracoabdominal, with dilation of stricture (with or without gastroplasty)	320.00	60	11.0+T
39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute	320.00	60	11.0+T
39541	chronic	320.00	60	11.0+T
39545	Imbrication of diaphragm for eventration, transthoracic or transabdominal, paralytic or nonparalytic	275.00	60	11.0+T
39560	Resection, diaphragm, with simple repair (eg, primary suture)	320.00	60	11.0+T
39561	with complex repair (eg, prosthetic material, local muscle flap)	328.00	60	11.0+T
39599	Unlisted procedure, diaphragm	BR		11.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

DIGESTIVE SYSTEM

LIPS

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

EXCISION

40490	Biopsy of lip	12.00	15	3.0+T
40500	Vermilionectomy (lip shave), with mucosal advancement	160.00	120	3.0+T
40510	Excision of lip; transverse wedge excision with primary closure	100.00	120	3.0+T
40520	V-excision with primary direct linear closure	100.00	120	3.0+T
	(For excision of mucous lesions, see 40810-40816)			
40525	full thickness, reconstruction with local flap (eg, Estlander or fan)	200.00	60	3.0+T
40527	full thickness, reconstruction with cross lip flap (Abbe-Estlander)	240.00	60	3.0+T
40530	Resection lip, more than one-fourth, without reconstruction	100.00	120	3.0+T
	(For reconstruction, see 13131 et seq)			

REPAIR (CHEILOPLASTY)

40650	Repair lip, full thickness; vermilion only	40.00	30	3.0+T
40652	up to half vertical height	68.00	30	3.0+T
40654	over one half vertical height, or complex	140.00	30	3.0+T
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral	280.00	90	6.0+T
40701	primary bilateral, one stage procedure	360.00	90	6.0+T
40702	primary bilateral, one of two stages	240.00	90	6.0+T
40720	secondary, by recreation of defect and reclosure	280.00	90	6.0+T
	(To report rhinoplasty only for nasal deformity secondary to congenital cleft lip, see 30460, 30462)			
40761	with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle	340.00	90	6.0+T
	(For repair cleft palate, see 42200 et seq) (For other reconstructive procedures, see 14060, 14061, 15120-15261, 15574, 15576, 15630)			
40799	Unlisted procedure, lips	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

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	8.00		3.0+T
40801	complicated	20.00		3.0+T
40804	Removal of embedded foreign body; simple	12.00	30	3.0+T
40805	complicated	BR	30	3.0+T
40806	Incision of labial frenum (frenotomy)	25.00		3.0+T

EXCISION, DESTRUCTION

40808	Biopsy, vestibule of mouth	12.00	15	3.0+T
40810	Excision of lesion of mucosa and submucosa vestibule of mouth; without repair	16.00	30	3.0+T
40812	with simple repair	20.00	30	3.0+T
40814	with complex repair	40.00	30	3.0+T
40816	complex with excision of underlying muscle	80.00	30	3.0+T
40818	Excision of mucosa as donor graft	BR		3.0+T
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)	25.00		3.0+T
40820	Destruction of lesion or scar by physical methods (eg, laser, thermal, cryo, chemical)	20.00	30	3.0+T

REPAIR

40830	Closure of laceration, vestibule of mouth; 2.5 cm or less	56.00	30	3.0+T
40831	over 2.5 cm or complex	120.00	30	3.0+T
40840	Vestibuloplasty; anterior	170.00	30	3.0+T
40842	posterior, unilateral	BR		3.0+T
40843	posterior, bilateral	BR		3.0+T
40844	entire arch	BR		3.0+T
40845	complex (including ridge extension, muscle repositioning)	260.00	30	3.0+T
	(For skin grafts, see 15000 et seq)			
40899	Unlisted procedure, vestibule of mouth	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	TONGUE AND FLOOR OF MOUTH			
	INCISION			
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual	8.00		3.0+T
41005	sublingual, superficial	8.00		3.0+T
41006	sublingual, deep, supramylohyoid	24.00		3.0+T
41007	submental space	24.00		3.0+T
41008	submandibular space	24.00		3.0+T
41009	masticator space	24.00		3.0+T
41010	Incision of lingual frenum (frenotomy)	25.00		3.0+T
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual	8.00		3.0+T
41016	submental	24.00		3.0+T
41017	submandibular	24.00		3.0+T
41018	masticator space	24.00		3.0+T
	(For frenoplasty, see 41520)			
	EXCISION			
41100	Biopsy of tongue; anterior two-thirds	20.00	30	3.0+T
41105	posterior one-third	12.00	30	3.0+T
41108	Biopsy of floor of mouth	12.00	15	3.0+T
41110	Excision of lesion of tongue without closure	160.00	120	6.0+T
41112	Excision of lesion of tongue with closure; anterior two-thirds	160.00	120	6.0+T
41113	posterior one-third	160.00	120	6.0+T
41114	with local tongue flap (List in addition to code 41112, 41113)	BR		
41115	Excision of lingual frenum (frenectomy)	25.00	30	3.0+T
41116	Excision, lesion of floor of mouth	60.00	30	3.0+T
41120	Glossectomy; less than one-half tongue	160.00	120	6.0+T
41130	hemiglossectomy	280.00	120	6.0+T
41135	partial, with unilateral radical neck dissection	480.00	120	6.0+T
41140	complete or total, with or without tracheostomy, without radical neck dissection	540.00	120	6.0+T
41145	complete or total, with or without tracheostomy, with unilateral radical neck dissection	620.00	120	6.0+T
41150	composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection	480.00	120	6.0+T
41153	composite procedure with resection floor of mouth, with suprahyoid neck dissection	520.00	120	6.0+T
41155	composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)	600.00	120	6.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	REPAIR			
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	56.00	30	3.0+T
41251	posterior one-third of tongue	56.00	30	3.0+T
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	120.00	30	3.0+T
	OTHER PROCEDURES			
41500	Fixation of tongue, mechanical, other than suture (eg, K-wire)	BR		3.0+T
41510	Suture of tongue to lip for micrognathia (Douglas type procedure)	75.00	30	3.0+T
41520	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	75.00	30	3.0+T
	(For frenotomy, see 40806, 41010)			
41599	Unlisted procedure, tongue, floor of mouth	BR		3.0+T
	DENTOALVEOLAR STRUCTURES			
	INCISION			
41800	Drainage of abscess, cyst, hematoma	8.00		3.0+T
41805	Removal of embedded foreign body; soft tissues	20.00	21	3.0+T
41806	bone	60.00	90	3.0+T
	EXCISION, DESTRUCTION			
41820	Gingivectomy, excision gingiva, each quadrant	BR		3.0+T
41821	Operculectomy, excision pericoronal tissues	BR		3.0+T
41822	Excision of fibrous tuberosities	BR		3.0+T
41823	Excision of osseous tuberosities	BR		3.0+T
41825	Excision of lesion or tumor (except listed above); without repair	BR		3.0+T
41826	with simple repair	BR		3.0+T
41827	with complex repair	100.00	60	3.0+T
	(For nonexcisional destruction, see 41850)			
41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)	BR		3.0+T
41830	Alveolectomy, including curettage of osteitis or sequestrectomy	70.00	60	3.0+T
41850	Destruction of lesion (except excision), dentoalveolar structures	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	OTHER PROCEDURES			
41870	Periodontal mucosal grafting	BR		3.0+T
41872	Gingivoplasty, each quadrant (specify)	BR		3.0+T
41874	Alveoloplasty each quadrant (specify)	120.00	60	3.0+T
	(For closure of lacerations, see 40830, 40831) (For segmental osteotomy, see 21206) (For reduction of fractures, see 21421-21490)			
41899	Unlisted procedure, dentoalveolar structures	BR		3.0+T
	PALATE AND UVULA			
	INCISION			
42000	Drainage of abscess of palate, uvula	8.00		3.0+T
	EXCISION, DESTRUCTION			
42100	Biopsy of palate, uvula	12.00	30	3.0+T
42104	Excision, lesion of palate, uvula; without closure	160.00	90	6.0+T
42106	with simple primary closure	160.00	90	6.0+T
42107	with local flap closure	BR		6.0+T
	(For skin graft, see 14040-14300; for mucosal graft, see 40818)			
42120	Resection of palate or extensive resection of lesion	160.00	90	6.0+T
	(For reconstruction of palate with extraoral tissue, see 14040-14300,15050, 15120, 15240, 15576)			
42140	Uvulectomy, excision of uvula	12.00	30	3.0+T
42145	Palatopharyngoplasty eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	320.00	90	6.0+T
42160	Destruction of lesion, palate or uvula (thermal, cryo or chemical)	180.00	60	3.0+T
	REPAIR			
42180	Repair, laceration of palate; up to 2 cm	56.00	30	3.0+T
42182	over 2 cm or complex	120.00	30	3.0+T
42200	Palatoplasty for cleft palate, soft and/or hard palate only	240.00	90	6.0+T
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	320.00	90	6.0+T
42210	with bone graft to alveolar ridge (includes obtaining graft)	320.00	90	6.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
42215	Palatoplasty for cleft palate; major revision	240.00	90	6.0+T
42220	secondary lengthening procedure	280.00	90	6.0+T
42225	attachment pharyngeal flap	240.00	90	6.0+T
42226	Lengthening of palate, and pharyngeal flap	240.00	90	6.0+T
42227	Lengthening of palate, with island flap	240.00	90	6.0+T
42235	Repair of anterior palate, including vomer flap	120.00	90	6.0+T
42260	Repair of nasolabial fistula	80.00	30	3.0+T
	(For repair of cleft lip, see 40700 et seq)			
42299	Unlisted procedure, palate, uvula	BR		3.0+T

SALIVARY GLANDS AND DUCTS

INCISION

42300	Drainage of abscess; parotid, simple	20.00		3.0+T
42305	parotid, complicated	20.00		3.0+T
42310	submaxillary or sublingual, intraoral	20.00		3.0+T
42320	submaxillary, external	20.00		3.0+T
42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	12.00		3.0+T
42335	submandibular (submaxillary), complicated, intraoral	40.00	30	3.0+T
42340	parotid, extraoral or complicated intraoral	100.00	30	3.0+T

EXCISION

42400	Biopsy of salivary gland; needle	20.00	30	3.0+T
	(For fine needle aspiration, see 10021, 10022)			
42405	incisional	20.00	30	3.0+T
	(If imaging guidance is performed, see 76003, 76360, 76393, 76942)			
42408	Excision of sublingual salivary cyst (ranula)	60.00	30	3.0+T
42409	Marsupialization of sublingual salivary cyst (ranula)	60.00	30	3.0+T
	(For fistulization of sublingual salivary cyst, see 42325)			
42410	Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection	80.00	60	3.0+T
42415	lateral lobe, with dissection and preservation of facial nerve	240.00	60	3.0+T
42420	total, with dissection and preservation of facial nerve	280.00	60	3.0+T
42425	total, en bloc removal with sacrifice of facial nerve	240.00	60	3.0+T
42426	total, with unilateral radical neck dissection	440.00	60	3.0+T
	(For suture or grafting of facial nerve, see 64864, 64865, 69740, 69745)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
42440	Excision of submandibular (submaxillary) gland	160.00	60	3.0+T
42450	Excision of sublingual gland	160.00	60	3.0+T
	REPAIR			
42500	Plastic repair of salivary duct, sialodochoplasty; primary or simple	140.00	60	3.0+T
42505	secondary or complicated	200.00	60	3.0+T
42507	Parotid duct diversion, bilateral (Wilke type procedure);	BR		3.0+T
42508	with excision of one submandibular gland	BR		3.0+T
42509	with excision of both submandibular glands	BR		3.0+T
42510	with ligation of both submandibular (Wharton's) ducts	180.00	60	3.0+T
	OTHER PROCEDURES			
42550	Injection procedure for sialography	4.00		3.0+T
	(For radiological supervision and interpretation, see 70390)			
42600	Closure salivary fistula	160.00	60	3.0+T
42650	Dilation salivary duct	4.00		3.0+T
42660	Dilation and catheterization of salivary duct, with or without injection	4.00		3.0+T
42665	Ligation salivary duct, intraoral	75.00	60	3.0+T
42699	Unlisted procedure, salivary glands or ducts	BR		3.0+T
	PHARYNX, ADENOIDS, AND TONSILS			
	INCISION			
42700	Incision and drainage abscess; peritonsillar	12.00		4.0+T
42720	retropharyngeal or parapharyngeal, intraoral approach	40.00	15	4.0+T
42725	retropharyngeal or parapharyngeal, external approach	140.00	15	4.0+T
	EXCISION, DESTRUCTION			
	(When resection codes are combined with radical neck dissection, use also 38720; for closure with myocutaneous or other flap, use appropriate number in addition)			
42800	Biopsy; oropharynx	12.00	15	3.0+T
42802	hypopharynx	20.00	15	3.0+T
42804	nasopharynx, visible lesion, simple	20.00	15	3.0+T
42806	nasopharynx, survey for unknown primary lesion	20.00	15	3.0+T
	(For laryngoscopic biopsy, see 31510, 31535, 31536)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
42808	Excision or destruction of lesion of pharynx, any method	40.00	90	3.0+T
42809	Removal of foreign body from pharynx	50.00	90	3.0+T
42810	Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues	60.00	30	3.0+T
42815	Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx	200.00	30	3.0+T
42820	Tonsillectomy and adenoidectomy; under age 12	60.00	30	3.0+T
42821	age 12 or over	80.00	30	3.0+T
42825	Tonsillectomy, primary or secondary; under age 12	60.00	30	3.0+T
42826	age 12 or over	80.00	30	3.0+T
42830	Adenoidectomy, primary; under age 12	40.00	30	3.0+T
42831	age 12 or over	40.00	30	3.0+T
42835	Adenoidectomy, secondary; under age 12	40.00	30	3.0+T
42836	age 12 or over	40.00	30	3.0+T
42842	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure	180.00	30	3.0+T
42844	closure with local flap (eg, tongue, buccal)	180.00	30	3.0+T
42845	closure with other flap	500.00	30	3.0+T
	(For closure with other flap(s), use appropriate number for flap(s). When combined with radical neck dissection, use also 38720.)			
42860	Excision of tonsil tags	40.00	30	3.0+T
42870	Excision or destruction lingual tonsil, any method (separate procedure)	40.00	30	3.0+T
	(For resection of the nasopharynx (eg, juvenile angiofibroma) by bicoronal and/or transzygomatic approach, see 61586 and 61600) (For excision and repair of hypopharyngeal diverticulum, cervical approach, see 43130)			
42890	Limited pharyngectomy	240.00	90	6.0+T
42892	Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls	300.00	90	6.0+T
42894	Resection of pharyngeal wall requiring closure with myocutaneous flap (When combined with radical neck dissection, use also 38720)	450.00	90	6.0+T
REPAIR				
42900	Suture pharynx for wound or injury	40.00	90	3.0+T
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	240.00	90	6.0+T
	(For pharyngeal flap, use 42225)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
42953	Pharyngoesophageal repair	240.00	90	12.0+T
	(For closure with myocutaneous or other flap, use appropriate number in addition)			
	OTHER PROCEDURES			
42955	Pharyngostomy (fistulization of pharynx, external for feeding)	240.00	90	6.0+T
42960	Control oropharyngeal hemorrhage primary or secondary (eg, post-tonsillectomy); simple	12.00		4.0+T
42961	complicated, requiring hospitalization	50.00	21	4.0+T
42962	with secondary surgical intervention	60.00	21	4.0+T
42970	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cautery	40.00		3.0+T
42971	complicated, requiring hospitalization	40.00		3.0+T
42972	with secondary surgical intervention	120.00	30	3.0+T
42999	Unlisted procedure, pharynx, adenoids, or tonsils	BR		3.0+T
	ESOPHAGUS			
	INCISION			
	(For esophageal intubation with laparotomy, use 43510)			
43020	Esophagotomy, cervical approach, with removal of foreign body	240.00	90	6.0+T
43030	Cricopharyngeal myotomy	180.00	90	6.0+T
43045	Esophagotomy, thoracic approach, with removal of foreign body	320.00	90	12.0+T
	EXCISION			
	(For gastrointestinal reconstruction for previous esophagectomy, see 43360, 43361)			
43100	Excision of lesion, esophagus, with primary repair; cervical approach	180.00	90	12.0+T
43101	thoracic or abdominal approach	300.00	90	12.0+T
43107	Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)	600.00	90	12.0+T
43108	with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)	700.00	90	12.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
43112	Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty	630.00	90	12.0+T
43113	with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	720.00	90	12.0+T
43116	Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction	650.00	90	12.0+T
	(For free jejunal graft with mircovascular anastomosis perfomed by another physician, use 43496)			
43117	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)	630.00	90	12.0+T
43118	with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	690.00	90	12.0+T
43121	Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy,with thoracic esophagogastrostomy, with or without pyloroplasty	600.00	90	12.0+T
43122	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty	600.00	90	12.0+T
43123	with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	700.00	90	12.0+T
43124	Total or partial esophagectomy, without reconstruction (any approach),with cervical esophagostomy	590.00	90	12.0+T
43130	Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach	250.00	90	12.0+T
43135	thoracic approach	325.00	90	12.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	ENDOSCOPY			
	(Surgical endoscopy always includes diagnostic endoscopy)			
43200	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing(separate procedure)	60.00	15	4.0+T
43201	with directed submucosal injection(s), any substance	80.00	30	4.0+T
	(For injection sclerosis of esophageal varcies, use 43204)			
43202	with biopsy, single or multiple	80.00	15	4.0+T
43204	with injection sclerosis of esophageal varices	80.00	30	4.0+T
43205	with band ligation of esophageal varcies	72.00	15	4.0+T
43215	with removal of foreign body	100.00	15	4.0+T
	(For radiological supervision and interpretation, see 74235)			
43216	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	79.00	15	4.0+T
43217	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	80.00	15	4.0+T
43219	with insertion of plastic tube or stent	100.00	15	4.0+T
43220	with balloon dilation (less than 30 mm diameter)	80.00	15	4.0+T
	(For dilation without visualization, see 43450-43453) (For endoscopic dilation with balloon 30 mm diameter or larger, 43458)			
43226	with insertion of guide wire followed by dilation over guide wire	80.00	15	4.0+T
	(For radiological supervision and interpretation, see 74360)			
43227	with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	100.00	15	4.0+T
43228	with ablation of tumor(s), polyp(s),or other lesions(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	100.00	15	4.0+T
43231	with endoscopic ultrasound examination	66.00	15	4.0+T
43232	with transendoscopic ultrasound-guided intramu or transmural fine needle aspiration/biopsy(s)	80.00	15	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
43234	Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope)(separate procedure)	60.00	7	4.0+T
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	80.00	7	4.0+T
43236	with directed submucosal injection(s), any substance	100.00	7	4.0+T
43237	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus	63.00		4.0+T
43238	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)	78.00		4.0+T
	(For injection sclerosis of esophageal and/or gastric varices, use 43243)			
43239	with biopsy, single or multiple	100.00	7	4.0+T
43240	with transmural drainage of pseudocyst	117.00	7	4.0+T
43241	with transendoscopic intraluminal tube or catheter placement	100.00	7	4.0+T
43242	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate) (Do not report 43242 in conjunction with 76942, 76975)	100.00	7	4.0+T
43243	with injection sclerosis of esophageal and/or gastric varices	100.00	7	4.0+T
43244	with band ligation of esophageal and/or gastric varices	87.00	15	4.0+T
43245	with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie) (Do not report 43245 in conjunction with 43256)	140.00	7	4.0+T
43246	with directed placement of percutaneous gastrostomy tube	240.00	45	5.0+T
	(For radiological supervision and interpretation, see 74350)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
43247	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body	240.00	45	5.0+T
	(For radiological supervision and interpretation, see 74235)			
43248	with insertion of guide wire followed by dilation of esophagus over guide wire	60.00	15	4.0+T
43249	with balloon dilation of esophagus (less than 30 mm diameter)	80.00	15	4.0+T
43250	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	97.00	15	4.0+T
43251	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	100.00	7	4.0+T
43255	with control of bleeding, any method	100.00	7	4.0+T
43256	with transendoscopic stent placement (includes predilation)	100.00	7	4.0+T
43258	with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	100.00	7	4.0+T
	(For injection sclerosis of esophageal varices, use 43204 or 43243)			
43259	with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate	75.00	15	4.0+T
	(For radiological supervision and interpretation, see 76975)			
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	160.00	7	4.0+T
43261	with biopsy, single or multiple	160.00	7	4.0+T
43262	with sphincterotomy/papillotomy	160.00	7	4.0+T
43263	with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)	160.00	7	4.0+T
43264	with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts	280.00	7	4.0+T
43265	with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method	200.00	7	4.0+T
43267	with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube	220.00	7	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
43268	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrogade insertion of tube or sent into bile or pancreatic duct	170.00	7	4.0+T
43269	with endoscopic retrograde removal of foreign body and/or change of tube or stent	220.00	7	4.0+T
43271	with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)	200.00	7	4.0+T
43272	with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	200.00	7	4.0+T

(For radiological supervision and interpretation, see 74328,74329, 74330)
(When done with sphincterotomy, also use 43262)

LAPAROSCOPY

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

43280	Laparascopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	320.00	90	4.0+T

(For open approach, use 43324)

43289	Unlisted laparoscopy procedure, esophagus	BR		4.0+T

REPAIR

43300	Esophagoplasty, (plastic repair or reconstruction), cervical approach; without repair of tracheoesophageal fistula	200.00	90	11.0+T
43305	with repair of tracheoesophageal fistula	360.00	90	11.0+T
43310	Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula	360.00	90	11.0+T
43312	with repair of tracheoesophageal fistula	650.00	90	11.0+T
43313	Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach, without repair of congenital tracheoesophageal fistula	BR	90	11.0+T
43314	with repair of congenital tracheoesophageal fistula	BR	90	11.0+T

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

43320	Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach	320.00	90	12.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
43324	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)	320.00	90	12.0+T
	(For laparoscopic procedure, use 43280)			
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)	320.00	90	12.0+T
	(For cricopharyngeal myotomy, see 43030)			
43326	with gastroplasty (eg, Collis)	320.00	90	12.0+T
43330	Esophagomyotomy (Heller type); abdominal approach	320.00	90	12.0+T
43331	thoracic approach	320.00	90	12.0+T
	(For thoracoscopic esophagomyotomy, use 32665)			
43340	Esophagojejunostomy (without total gastrectomy); abdominal approach	400.00	90	11.0+T
43341	thoracic approach	400.00	90	11.0+T
43350	Esophagostomy, fistulization of esophagus, external; abdominal approach	240.00	90	6.0+T
43351	thoracic approach	240.00	90	6.0+T
43352	cervical approach	240.00	90	6.0+T
43360	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty	600.00	90	12.0+T
43361	with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	650.00	90	12.0+T
43400	Ligation, direct, esophageal varices	320.00	90	12.0+T
43401	Transection of esophagus with repair, for esophageal varices	320.00	90	12.0+T
43405	Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation	342.00	90	12.0+T
43410	Suture of esophageal wound or injury; cervical approach	BR		7.0+T
43415	transthoracic or transabdominal approach	280.00	90	12.0+T
43420	Closure of esophagostomy or fistula; cervical approach	180.00	90	7.0+T
43425	transthoracic or transabdominal approach	280.00	90	12.0+T
	(For repair of esophageal hiatal hernia, see 39520 et seq)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	MANIPULATION			
	(For associated esophagogram, use 74220)			
43450	Dilation of esophagus; by unguided sound or bougie, single or multiple passes	20.00		3.0+T
43453	over guide wire	20.00		3.0+T
	(For dilation with direct visualization, see 43220)			
43456	by balloon or dilator, retrograde	20.00		3.0+T
43458	with balloon (30 mm diameter or larger) for achalasia	80.00	15	4.0+T
	(For radiological supervision and interpretation, see 74360; (For dilation with balloon less than 30 mm diameter, see 43220)			
43460	Esophagogastric tamponade, with balloon (Sengstaaken type)	20.00		3.0+T
	(For removal of esophageal foreign body by balloon catheter, see 43215, 43247, 74235)			
	OTHER PROCEDURES			
43496	Free jejunum transfer with microvascular anastomosis (Do not report 43496 in addition to code 69990)	600.00	90	6.0+T
43499	Unlisted procedure, esophagus	BR		3.0+T
	STOMACH			
	INCISION			
43500	Gastrotomy; with exploration or foreign body removal	200.00	45	5.0+T
43501	with suture repair of bleeding ulcer	200.00	45	6.0+T
43502	with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss)	282.00	45	6.0+T
43510	with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin)	199.00	45	6.0+T
43520	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation) (Do not report modifier –63 in conjunction with 43520)	200.00	45	6.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	EXCISION			
43600	Biopsy of stomach; by capsule, tube, peroral (one or more specimens)	20.00	7	4.0+T
43605	by laparotomy	200.00	45	5.0+T
43610	Excision, local; ulcer or benign tumor of stomach	240.00	45	5.0+T
43611	malignant tumor of stomach	243.00	90	5.0+T
43620	Gastrectomy, total; with esophagoenterostomy	400.00	90	6.0+T
43621	with Roux-en-Y reconstruction	435.00	90	6.0+T
43622	with formation of intestinal pouch, any type	450.00	90	6.0+T
43631	Gastrectomy, partial, distal; with gastroduodenostomy	361.00	90	6.0+T
43632	with gastrojejunostomy	361.00	90	6.0+T
43633	with Roux-en-Y reconstruction	366.00	90	6.0+T
43634	with formation of intestinal pouch	BR	90	6.0+T
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)	37.00		6.0+T
43640	Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective	280.00	60	6.0+T
43641	parietal cell (highly selective)	280.00	60	6.0+T
	(For pyloroplasty, see 43800; for vagotomy, see 64752-64760) (For regional thoracic lymphadenectomy, see 38746) (For regional abdominal lymphadenectomy, see 38747)			
	LAPAROSCOPY			
	Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.			
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and roux-en-y gastroenterostomy (roux limb 150 cm or less)	453.00	90	6.0+T
43645	with gastric bypass and small intestine reconstruction to limit absorption	489.00	90	6.0+T
43651	Laparoscopy, surgical; transection of vagus nerves, truncal	174.00	90	6.0+T
43652	transection of vagus nerves, selective or highly selective	207.00	90	6.0+T
43653	gastrostomy, without construction of gastric tube (eg, Stamm procedure)(separate procedure)	145.00	90	6.0+T
43659	Unlisted laparoscopy procedure, stomach	BR		6.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	INTRODUCTION			
	(For radiological supervision and interpretation, see 74350, 75984)			
	(For endoscopic placement of gastrostomy tube, see 43246)			
43750	Percutaneous placement of gastrostomy tube	160.00	30	3.0+T
43752	Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)	7.00		3.0+T
	(If imaging guidance is performed, use 76000) (For enteric tube placement, see 44500, 74340) (Do not report 43752 in conjunction with critical care codes 99291-99292, or neonatal intensive care codes 99295-99298)			
43760	Change of gastrostomy tube	20.00		
43761	Repositioning of the gastric feeding tube, any method, through the duodenum for enteric nutrition	60.00		3.0+T
	BARIATRIC SURGERY			
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components)	286.00	90	6.0+T
43771	revision of adjustable gastric band component only	329.00	90	6.0+T
43772	removal of adjustable gastric band component only	251.00	90	6.0+T
43773	removal and replacement of adjustable gastric band component only	329.00	90	6.0+T
43774	removal of adjustable gastric band and subcutaneous port components	251.00	90	6.0+T
	OTHER PROCEDURES			
43800	Pyloroplasty	200.00	45	5.0+T
	(For pyloroplasty and vagotomy, see 43640)			
43810	Gastroduodenostomy	240.00	45	5.0+T
43820	Gastrojejunostomy; without vagotomy	240.00	45	5.0+T
43825	with vagotomy, any type	300.00		6.0+T
43830	Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)	160.00	45	5.0+T
43831	neonatal, for feeding (Do not report modifier –63 in conjunction with 43831)	160.00	45	5.0+T
43832	with construction of gastric tube (eg, Janeway procedure)	160.00	45	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
43840	Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	200.00	45	6.0+T
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	700.00	90	6.0+T
43843	other than vertical-banded gastroplasty	700.00	90	6.0+T
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)	BR	90	6.0+T
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	800.00	90	6.0+T
43847	with small intestine reconstruction to limit absorption	800.00	90	6.0+T
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric band (separate procedure)	432.00	60	6.0+T
43850	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy	360.00	60	6.0+T
43855	with vagotomy	400.00	60	6.0+T
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy	360.00	60	6.0+T
43865	with vagotomy	400.00	60	6.0+T
43870	Closure of gastrostomy, surgical	160.00	45	5.0+T
43880	Closure of gastrocolic fistula	320.00	45	5.0+T
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	76.00	90	5.0+T
43887	removal of subcutaneous port component only	75.00	90	5.0+T
43888	removal and replacement of subcutaneous port component only	106.00	90	5.0+T
43999	Unlisted procedure, stomach	BR		5.0+T

INTESTINES (EXCEPT RECTUM)

INCISION

44005	Enterolysis (freeing of intestinal adhesion) (separate procedure) (For laparoscopic approach, use 44200)	240.00	45	5.0+T
44010	Duodenotomy, for exploration, biopsy(s), or foreign body removal	240.00	60	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
44015	Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method (List separately in addition to primary procedure)	160.00		4.0+T
44020	Enterotomy, small bowel, other than duodenum; for exploration, biopsy(s), or foreign body removal	240.00	60	4.0+T
44021	for decompression (eg, Baker tube)	240.00	60	4.0+T
44025	Colotomy, for exploration, biopsy(s), or foreign body removal	260.00	60	4.0+T
44050	Reduction of volvulus, intussusception, internal hernia, by laparotomy	240.00	90	5.0+T
44055	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg, Ladd procedure)	240.00	90	5.0+T

EXCISION

44100	Biopsy of intestine by capsule, tube, peroral (one or more specimens)	20.00	7	4.0+T
44110	Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy	240.00	60	4.0+T
44111	multiple enterotomies	280.00	60	4.0+T
44120	Enterectomy, resection of small intestine; single resection and anastomosis (Do not report 44120 in addition to 45136)	280.00	60	4.0+T
44121	each additional resection and anastomosis (List separately in addition to primary procedure)	78.00		
44125	with enterostomy	280.00	60	4.0+T
44126	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine, without tapering	580.00	90	5.0+T
44127	with tapering	666.00	90	5.0+T
44128	each additional resection and anastomosis (List separately in addition to primary procedure) (Use 44128 in conjunction with codes 44126, 44127)	72.00		
	(Do not report modifier –63 in conjunction with 44126, 44127, 44128)			
44130	Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)	240.00	90	5.0+T
44133	Donor enterectomy, open, with preparation and maintenance of allograft; partial, from living donor	400.00	90	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
44135	Intestinal allotransplantation; from cadeavor donor	400.00	90	5.0+T
44136	from living donor	800.00	90	5.0+T
44137	Removal of transplanted intestinal allograft, complete	BR		5.0+T
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)	39.00		
44140	Colectomy, partial; with anastomosis	320.00	90	5.0+T
44141	with skin level cecostomy or colostomy (For laparoscopic procedure, use 44204)	400.00	90	5.0+T
44143	with end colostomy and closure of distal segment (Hartmann type procedure) (For laparoscopic procedure, use 44206)	325.00	90	5.0+T
44144	with resection, with colostomy or ileostomy and creation of mucofistula	310.00	90	5.0+T
44145	with coloproctostomy (low pelvic anastomosis) (For laparoscopic procedure, use 44207)	320.00	90	5.0+T
44146	with coloproctostomy (low pelvic anastomosis), with colostomy (For laparoscopic procedure, use 44208)	320.00	90	5.0+T
44147	abdominal and transanal approach	380.00	90	5.0+T
44150	Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy (For laparoscopic procedure, use 44210)	440.00	90	6.0+T
44151	with continent ileostomy	400.00	90	6.0+T
44152	with rectal mucosectomy, ileoanal anastomosis, with or without loop ileostomy (For laparoscopic procedure,use 44211)	480.00	90	6.0+T
44153	with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy (For laparoscopic procedure, use 44211)	530.00	90	6.0+T
44155	Colectomy, total, abdominal, with proctectomy; with ileostomy (For laparoscopic procedure, use 44212)	480.00	90	6.0+T
44156	with continent ileostomy	460.00	90	6.0+T
44160	Colectomy, partial, with removal of terminal ileum and ileocolostomy	310.00	90	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	LAPAROSCOPY			
	Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.			
44180	Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion)(separate procedure)	251.00	90	6.0+T
	(For laparoscopy with salpingolysis, ovariolysis, use 58660)			
44186	Laparoscopy, surgical; jejunostomy (eg, for decompression or feeding)	172.00	90	6.0+T
44187	ileostomy or jejunostomy, non-tube	287.00	90	6.0+T
44188	Laparoscopy, surgical, colostomy or skin level cecostomy	315.00	90	6.0+T
44202	enterectomy, resection of small intestine, single resection and anastomosis	381.00	90	6.0+T
44203	each additional small intestine resection and anastomosis (List separately in addition to primary procedure) (Use 44203 in conjunction with code 44202) (For open procedure, see 44120, 44121)	70.00		
44204	colectomy, partial, with anastomosis (For open procedure, use 44140)	402.00	90	6.0+T
44205	colectomy, partial, with removal of terminal ileum with ileocolostomy (For open procedure, use 44160)	356.00	90	6.0+T
44206	Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure) (For open procedure, use 44143)	432.00	90	6.0+T
44207	colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) (For open procedure, use 44145)	473.00	90	6.0+T
44208	colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy (For open procedure, use 44146)	512.00	90	6.0+T
44210	colectomy, total, abdominal, without protectomy, with ileostomy or ileoproctostomy (For open procedure, use 44150)	453.00	90	6.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
44211	Laparoscopy, surgical;colectomy, total, abdominal,with protectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy (For open procedure, use 44152, 44153)	563.00	90	6.0+T
44212	colectomy, total, abdominal, with proctectomy, with ileostomy (For open procedure, use 44155)	563.00	90	6.0+T
44213	Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)	55.00		
44227	Laparoscopy, surgical, closure of enterostomy, large or small intestine, with resection and anastomosis	457.00	90	6.0+T
44238	Unlisted laparoscopy procedure, intestine (except rectum)	BR	90	6.0+T
ENTEROSTOMY - EXTERNAL FISTULIZATION OF INTESTINES				
44300	Enterostomy, or cecostomy, tube (eg, for decompression or feeding) (separate procedure)	170.00	90	4.0+T
44310	Ileostomy or jejunostomy, non-tube (Do not report 44310 in conjunction with 44144, 44150-44153, 44155, 44156, 45113, 45119, 45136)	200.00	90	4.0+T
44312	Revision of ileostomy; simple (release of superficial scar) (separate procedure)	20.00	90	3.0+T
44314	complicated (reconstruction in depth) (separate procedure)	100.00	90	4.0+T
44316	Continent ileostomy (Kock procedure) (separate procedure) (For fiberoptic evaluation, see 44385)	200.00	90	4.0+T
44320	Colostomy or skin level cecostomy;	200.00	90	4.0+T
44322	with multiple biopsies (eg, for congenital megacolon) (separate procedure)	250.00	90	4.0+T
44340	Revision of colostomy; simple (release of superficial scar) (separate procedure)	20.00	90	3.0+T
44345	complicated (reconstruction in depth) (separate procedure)	100.00	90	4.0+T
44346	with repair of paracolostomy hernia (separate procedure)	220.00	90	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	ENDOSCOPY, SMALL INTESTINE AND STOMAL			
	(For upper gastrointestinal endoscopy, see 43234-43258)			
	(Surgical endoscopy always includes diagnostic endoscopy)			
44360	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	80.00	7	4.0+T
44361	with biopsy, single or multiple	100.00	7	4.0+T
44363	with removal of foreign body	105.00	7	4.0+T
44364	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	120.00	7	4.0+T
44365	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	103.00	7	4.0+T
44366	with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	120.00	7	4.0+T
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	120.00	7	4.0+T
44370	with transendoscopic stent placement (includes predilation)	120.00	7	4.0+T
44372	with placement of percutaneous jejunostomy tube	130.00	7	4.0+T
44373	with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube	120.00	7	4.0+T
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)	103.00	7	4.0+T
44377	with biopsy, single or multiple	108.00	7	4.0+T
44378	with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	141.00	7	4.0+T
44379	with transendonscopic stent placement (includes predilation)	141.00	7	4.0+T
44380	Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	80.00	7	4.0+T
44382	with biopsy, single or multiple	100.00	7	4.0+T
44383	with transendoscopic stent placement (inlcudes predilation)	100.00	7	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
44385	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	80.00	7	4.0+T
44386	with biopsy, single or multiple	100.00	7	4.0+T
44388	Colonscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	70.00	7	4.0+T
44389	with biopsy, single or multiple	150.00	15	4.0+T
44390	with removal of foreign body	150.00	15	4.0+T
44391	with control of bleeding,(eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	BR		3.0+T
44392	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	150.00	15	4.0+T
44393	with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	150.00	15	4.0+T
44394	with removal of tumor(s), polyp(s), or other lesion(s) by snare techniques	150.00	15	4.0+T
	(For colonoscopy per rectum, see 45330-45385)			
44397	with transendoscopic stent placement (includes predilation)	70.00	15	4.0+T

INTRODUCTION

44500	Introduction of long gastrointestinal tube (eg, Miller-Abbott)(separate procedure)	7.00		
	(For radiological supervision and interpretation, see 74340)			

REPAIR

44602	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury, or rupture; single perforation	240.00	90	5.0+T
44603	multiple perforations	261.00	90	5.0+T
44604	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy	244.00	90	5.0+T
44605	with colostomy	280.00	90	5.0+T
44615	Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction	203.00	90	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
44620	Closure of enterostomy, large or small intestine;	160.00	90	5.0+T
44625	with resection and anastomosis other than colorectal	285.00	90	5.0+T
44626	with resection and colorecta anastomosis (eg, closure of Hartmann type procedure)	379.00	90	5.0+T
44640	Closure of intestinal cutaneous fistula	200.00	90	5.0+T
44650	Closure of enteroenteric or enterocolic fistula	200.00	90	5.0+T
44660	Closure of enterovesical fistula; without intestinal or bladder resection	200.00	90	5.0+T
44661	with intestine and/or bladder resection	415.00	90	5.0+T
	(For fistula closure, renocolic, see 50525, 50526; gastrocolic, see 43880; rectovesical, see 45800, 45805)			
44680	Intestinal plication (separate procedure)	240.00	90	4.0+T
44700	Exclusion of small intestine from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum)	257.00	90	4.0+T
44701	Intraoperative colonic lavage (List separately in addition to primary procedure) (Use 44701 in conjunction with codes 44140, 44145, 44150, or 44604 as appropriate) (Do not report 44701 in conjunction with 44300, 44950-44960)	47.00		
44799	Unlisted procedure, intestine	BR		5.0+T
	(For unlisted laparoscopic procedure, intestine except rectum, use 44238)			

MECKEL'S DIVERTICULUM AND THE MESENTERY

EXCISION

44800	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	200.00	45	4.0+T
44820	Excision of lesion of mesentery (separate procedure)	200.00	45	4.0+T
	(For excision with bowel resection, see 44120 or 44140 et seq)			

SUTURE

44850	Suture of mesentery (separate procedure)	160.00	45	4.0+T
	(For reduction and repair of internal hernia, see 44050)			
44899	Unlisted procedure, Meckel's diverticulum	BR		4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

APPENDIX

INCISION

44900	Incision and drainage of appendiceal abscess, open	120.00	45	4.0+T
44901	percutaneous	86.00	45	4.0+T

(For radiological supervision and interpretation, use 75989)

EXCISION

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

44950	Appendectomy;	160.00	45	4.0+T
44955	when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to primary procedure)	160.00	45	4.0+T
44960	for ruptured appendix with abscess or generalized peritonitis	160.00	45	4.0+T

LAPAROSCOPY

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

44970	Laparoscopy, surgical, appendectomy	152.00	45	4.0+T
44979	Unlisted laparoscopy procedure, appendix	BR		4.0+T

RECTUM

INCISION

45000	Transrectal drainage of pelvic abscess	60.00	15	3.0+T
45005	Incision and drainage of submucosal abscess, rectum	8.00		3.0+T
45020	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess (see also 46050, 46060)	80.00	30	3.0+T

EXCISION

45100	Biopsy of anorectal wall, anal approach (eg, congenital megacolon)	20.00	15	3.0+T

(For endoscopic biopsy, see 45305)

45108	Anorectal myomectomy	160.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
45110	Proctectomy; complete, combined abdominoperineal, with colostomy	400.00	90	6.0+T
45111	partial resection of rectum, transabdominal approach	300.00	90	4.0+T
45112	Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis) (For colo-anal anastomosis with colonic reservoir or pouch, use 45119)	400.00	90	7.0+T
45113	Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S OR J), with or without loop ileostomy	474.00	90	7.0+T
45114	Proctectomy, partial, with anastomosis; abdominal and transsacral approach	400.00	90	6.0+T
45116	transsacral approach only (Kraske type)	320.00	90	4.0+T
45119	Protectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservior (eg, J-pouch), with diverting enterostomy when performed	450.00	90	7.0+T
45120	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull-through procedure and anastomosis (eg, Swenson, Duhamel, or Soave type operation)	400.00	90	7.0+T
45121	with subtotal or total colectomy, with multiple biopsies	350.00	90	7.0+T
45123	Proctectomy, partial, without anastomosis, perineal approach	296.00	90	4.0+T
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	800.00	90	15.0+T
45130	Excision of rectal procidentia, with anastomosis; perineal approach	240.00	90	4.0+T
45135	abdominal and perineal approach	400.00	90	6.0+T
45136	Excision of ileoanal reservoir with Ileostomy (Do not report 45136 in addition to 44005, 44120, 44310)	453.00	90	4.0+T
45150	Division of stricture of rectum	80.00	90	4.0+T
45160	Excision of rectal tumor by proctotomy, transacral or transcoccygeal approach	320.00	90	4.0+T
45170	Excision of rectal tumor, transanal approach	160.00	90	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
DESTRUCTION				
45190	Destruction of rectal tumor, (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach	151.00	90	4.0+T
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)	12.00	15	3.0+T
45303	with dilation, (eg, balloon, guide wire, bougie)	20.00	15	3.0+T
	(For radiological supervision and interpretation, use 74360)			
45305	with biopsy, single or multiple	20.00	15	3.0+T
45307	with removal of foreign body	28.00	15	3.0+T
45308	with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	35.00	15	3.0+T
45309	with removal of single tumor, polyp, or other lesion by snare technique	35.00	15	3.0+T
45315	with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	36.00	15	3.0+T
45317	with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	40.00	15	3.0+T
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)	55.00	15	3.0+T
45321	with decompression of volvulus	42.00	15	3.0+T
45327	with transendoscopic stent placement (includes predilation)	47.00	15	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
45330	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	25.00	15	3.0+T
45331	with biopsy, single or multiple	33.00	15	3.0+T
45332	with removal of foreign body	42.00	15	3.0+T
45333	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	51.00	15	3.0+T
45334	with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	64.00		3.0+T
45335	with directed submucosal injection(s), any substance	64.00	15	3.0+T
45337	with decompression of volvulus, any method	64.00	7	4.0+T
45338	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	51.00	15	3.0+T
45339	with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	73.00	15	3.0+T
45340	with dilation by balloon, 1 or more strictures (Do not report 45340 in conjunction with 45345)	96.00	15	3.0+T
45341	with endoscopic ultrasound examination	58.00	15	3.0+T
45342	with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	65.00	15	3.0+T
	(Do not report 76975 in conjunction with codes 45341, 45342) (For transrectal ultrasound utilizing rigid probe device, use 76872)			
45345	with transendoscopic stent placement (includes predilation)	45.00	15	3.0+T
45355	Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple	52.00	15	3.0+T
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	80.00	7	4.0+T
45379	with removal of foreign body	160.00	15	4.0+T
45380	with biopsy, single or multiple	160.00	15	4.0+T
45381	with directed submucosal injection(s), any substance	160.00	15	4.0+T
45382	with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	160.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
45383	Colonoscopy, flexible, proximal to splenic flexure with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	160.00	15	4.0+T
45384	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	140.00	15	4.0+T
45385	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	140.00	15	4.0+T
	(For small bowel and stomal endoscopy, see 44360-44393)			
45386	with dilation by balloon, 1 or more strictures (Do not report 45386 in conjunction with 45387)	160.00	15	4.0+T
45387	with transendoscopic stent placement (includes predilation)	90.00	15	4.0+T
45391	Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination	80.00		4.0+T
45392	with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	101.00		4.0+T
LAPAROSCOPY				
45395	Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy	500.00	90	6.0+T
45397	proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, j-pouch), with diverting enterostomy, when performed	543.00	90	6.0+T
45400	Laparoscopy, surgical; proctopexy (for prolapse)	292.00	90	6.0+T
45402	proctopexy (for prolapse), with sigmoid resection	396.00	90	6.0+T
45499	Unlisted laparoscopy procedure, rectum	BR		6.0+T
REPAIR				
45500	Proctoplasty; for stenosis	160.00	90	3.0+T
45505	for prolapse of mucous membrane	160.00	90	3.0+T
45520	Perirectal injection of sclerosing solution for prolapse	40.00	30	
45540	Proctopexy (eg, for prolapse); abdominal approach	240.00	90	5.0+T
45541	perineal approach	240.00	90	5.0+T
45550	with sigmoid resection, abdominal approach	360.00	90	5.0+T
45560	Repair of rectocele (separate procedure)	120.00	60	5.0+T
	(For repair of rectocele with posterior colporrhapy, see 57250)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
45562	Exploration, repair, and presacral drainage for rectal injury;	224.00	90	5.0+T
45563	with colostomy	353.00	90	5.0+T
45800	Closure of rectovesical fistula;	240.00	90	5.0+T
45805	with colostomy	280.00	90	5.0+T
45820	Closure of rectourethral fistula;	280.00	90	5.0+T
45825	with colostomy	320.00	90	5.0+T
	(For rectovaginal fistula closure, see 57300-57308)			

MANIPULATION

45900	Reduction of procidentia (separate procedure) under anesthesia	8.00		3.0+T
45905	Dilation of anal sphincter (separate procedure) under anesthesia other than local	25.00		3.0+T
45910	Dilation of rectal stricture (separate procedure) under anesthesia other than local	31.00		3.0+T
45915	Removal of fecal impaction or foreign body (separate procedure) under anesthesia	32.00		3.0+T
45999	Unlisted procedure, rectum	BR		3.0+T
	(For unlisted laparoscopic procedure, rectum, use 44239)			

ANUS

INCISION

46020	Placement of seton (Do not report in addition to 46060, 46280, 46600)	67.00	10	3.0+T
46030	Removal of anal seton, other marker	8.00	15	
46040	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)	40.00	15	3.0+T
46045	Incision and drainage of intramural, intramuscular or submucosal abscess, transanal, under anesthesia	40.00	15	3.0+T
46050	Incision and drainage, perianal abscess, superficial (see also 45020, 46060)	8.00		3.0+T
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)	160.00	90	3.0+T
46070	Incision, anal septum (infant) (Do not report modifier –63 in conjunction with 46070)	20.00	30	3.0+T
	(For anoplasty, see 46700-46705)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
46080	Sphincterotomy, anal, division of sphincter (separate procedure)	20.00		3.0+T
46083	Incision of thrombosed hemorrhoid, external	12.00		3.0+T
EXCISION				
46200	Fissurectomy, with or without sphincterotomy	80.00	90	3.0+T
46210	Cryptectomy; single	20.00	30	
46211	multiple (separate procedure)	120.00	90	3.0+T
46220	Papillectomy or excision of single tag, anus (separate procedure)	12.00	15	
46221	Hemorrhoidectomy, by simple ligature (eg, rubber band)	28.00	15	3.0+T
46230	Excision of external hemorrhoid tags and/or multiple papillae	20.00	15	
46250	Hemorrhoidectomy, external, complete	80.00	90	3.0+T
46255	Hemorrhoidectomy, internal and external, simple;	120.00	90	3.0+T
46257	with fissurectomy	120.00	90	3.0+T
46258	with fistulectomy, with or without fissurectomy	160.00	90	3.0+T
46260	Hemorrhoidectomy, internal and external, complex or extensive;	160.00	90	3.0+T
46261	with fissurectomy	160.00	90	3.0+T
46262	with fistulectomy, with or without fissurectomy	160.00	90	3.0+T
46270	Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous	40.00	30	3.0+T
46275	submuscular	160.00	90	3.0+T
46280	complex or multiple, with or without placement of seton (Do not report 46280 in addition to 46020)	180.00	90	3.0+T
46285	second stage	40.00	60	3.0+T
46288	Closure of anal fistula with rectal advancement flap	121.00	90	3.0+T
46320	Enucleation or excision of external thrombotic hemorrhoid	12.00		3.0+T
INTRODUCTION				
46500	Injection of sclerosing solution, hemorrhoids	8.00		3.0+T
46505	Chemodenervation of internal anal sphincter	47.00	10	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	ENDOSCOPY			
	(Surgical endoscopy always includes diagnostic endoscopy)			
46600	Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	4.00		3.0+T
46604	with dilation, (eg, balloon, guide wire, bougie)	4.00		3.0+T
46606	with biopsy, single or multiple	9.00		3.0+T
46608	with removal of foreign body	28.00	15	3.0+T
46610	with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	28.00	15	3.0+T
46611	with removal of single tumor, polyp, or other lesion by snare technique	27.00	15	3.0+T
46612	with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	36.00	15	3.0+T
46614	with control of bleeding, (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	41.00	15	3.0+T
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	49.00	15	3.0+T
	REPAIR			
	(Do not report modifier –63 in conjunction with 46705, 46715, 46716, 46730, 46735, 46740, 46742 or 46744)			
46700	Anoplasty, plastic operation for stricture; adult	160.00	90	5.0+T
46705	infant	160.00	90	5.0+T
	(For simple incision of anal septum, see 46070)			
46706	Repair of anal fistula with fibrin glue	41.00	15	3.0+T
46710	Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach	165.00	90	7.0+T
46712	combined transperineal and transabdominal approach	345.00	90	7.0+T
46715	Repair of low imperforate anus; with an operineal fistula ("cut-back" procedure)	200.00	90	5.0+T
46716	with transposition of anoperineal or anovestibular fistula	200.00	90	5.0+T
46730	Repair of high imperforate anus without fistula; perineal or sacroperineal approach	200.00	90	5.0+T
46735	combined transabdominal and sacroperineal approaches	320.00	90	7.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
46740	Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach	280.00	90	5.0+T
46742	combined transabdominal and sacroperineal approaches	BR	90	7.0+T
46744	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty; sacroperineal approach	550.00	90	7.0+T
46746	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach	BR	90	7.0+T
46748	with vaginal lengthening by intestinal graft and pedicle flaps	625.00	90	7.0+T
46750	Sphincteroplasty, anal, for incontinence or prolapse; adult	160.00	90	4.0+T
46751	child	160.00	90	4.0+T
46753	Graft (Thiersch operation) for rectal incontinence and/or prolapse	100.00	30	4.0+T
46754	Removal of Thiersch wire or suture, anal canal	BR		4.0+T
46760	Sphincteroplasty, anal, for incontinence, adult; muscle transplant	200.00	90	4.0+T
46761	levator muscle imbrication (Park posterior anal repair)	190.00	90	4.0+T
46762	implantation artificial sphincter	170.00	90	4.0+T
DESTRUCTION				
46900	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	45.00	30	3.0+T
46910	electrodesiccation	70.00	30	3.0+T
46916	cryosurgery	70.00	30	3.0+T
46917	laser surgery	70.00	30	3.0+T
46922	surgical excision	80.00	30	3.0+T
46924	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	62.00	30	3.0+T
46934	Destruction of hemorrhoids, any method;internal	56.00		3.0+T
46935	external	46.00		3.0+T
46936	internal and external	72.00		3.0+T
46937	Cryosurgery of rectal tumor; benign	59.00		3.0+T
46938	malignant	80.00		3.0+T
46940	Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); initial	31.00		3.0+T
46942	subsequent	27.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	SUTURE			
46945	Ligation of internal hemorrhoids; single procedure	28.00	15	3.0+T
46946	multiple procedures	28.00	15	3.0+T
46947	Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling	37.00	90	3.0+T
46999	Unlisted procedure, anus	BR		3.0+T
	LIVER			
	INCISION			
	(If imaging guidance is preformed, see 76003, 76360, 76393, 76942)			
	(For fine needle aspiration with 47000, 47001, see 10021, 10022)			
47000	Biopsy of liver, needle; percutaneous	20.00		3.0+T
47001	when done for indicated purpose at time of other major procedure (List separately in addition to primary procedure)	20.00		3.0+T
47010	Hepatotomy; for open drainage of abscess or cyst, one or two stages	280.00	60	3.0+T
47011	for percutaneous drainage of abscess or cyst, one or two stages	40.00		3.0+T
47015	Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cyst(s) or abscess(es)	179.00	60	3.0+T
	EXCISION			
47100	Biopsy of liver, wedge	200.00	45	3.0+T
47120	Hepatectomy, resection of liver; partial lobectomy	320.00	45	9.0+T
47122	trisegmentectomy	340.00	45	9.0+T
47125	total left lobectomy	320.00	45	9.0+T
47130	total right lobectomy	320.00	45	9.0+T
	LIVER TRANSPLANTATION			
47135	Liver allotransplantation; orthotopic, partial or whole, from living donor, any age	800.00	45	15.0+T
	REPAIR			
47300	Marsupialization of cyst or abscess of liver	280.00	60	6.0+T
47350	Management of liver hemorrhage; simple suture of liver wound or injury	240.00	45	9.0+T
47360	complex, suture of liver wound or injury, with or without hepatic artery ligation	360.00	45	9.0+T
47361	exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver	495.00	90	9.0+T
47362	re-exploration of hepatic wound for removal of packing	177.00	90	9.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	LAPAROSCOPY			
	Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (Peritoneoscopy)(separate procedure), use 49320.			
47370	Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency (For imaging guidance, use 76490)	280.00	90	3.0+T
47371	cryosurgical (For imaging guidance, use 76490)	264.00	90	3.0+T
47379	Unlisted laparoscopic procedure, liver	BR		3.0+T
	OTHER PROCEDURES			
47380	Ablation, open, of one or more liver tumor(s); radiofrequency (For imaging guidance, use 76490)	329.00	90	6.0+T
47381	cryosurgical (For imaging guidance, use 76490)	325.00	90	6.0+T
47382	Ablation, one or more liver tumor(s), percutaneous, radiofrequency	196.00	10	3.0+T
	(For imaging guidance and monitoring, see code 76362, 76394, or 76490)			
47399	Unlisted procedure, liver	BR		3.0+T
	BILIARY TRACT			
	INCISION			
47400	Hepaticotomy or hepaticostomy with exploration, drainage, or removal of calculus	280.00	45	6.0+T
47420	Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; without transduodenal sphincterotomy or sphincteroplasty	280.00	45	6.0+T
47425	with transduodenal sphincterotomy or sphincteroplasty	320.00	60	6.0+T
47460	Transduodenal sphincterotomy or sphincteroplasty, with or without transduodenal extraction of calculus (separate procedure)	320.00	60	6.0+T
47480	Cholecystotomy or cholecystostomy with exploration, drainage, or removal of calculus (separate procedure)	200.00	45	5.0+T
47490	Percutaneous cholecystostomy	150.00	30	3.0+T
	(For radiological supervision and interpretation, see 75989)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	INTRODUCTION			
47500	Injection procedure for percutaneous transhepatic cholangiography (For radiological supervision and interpretation, see 74320)	40.00	7	3.0+T
47505	Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube) (For radiological supervision and interpretation, use 74305)	27.00	7	3.0+T
47510	Introduction of percutaneous transhepatic catheter for biliary drainage (For radiological supervision and interpretation, see 75980)	114.00	90	3.0+T
47511	Introduction of percutaneous transhepatic stent for internal and external biliary drainage (For radiological supervision and interpretation, see 75982)	142.00	90	3.0+T
47525	Change of percutaneous biliary drainage catheter (For radiological supervision and interpretation, see 75984)	78.00	10	3.0+T
47530	Revision and/or reinsertion of transhepatic tube (For radiological supervision and interpretation, see 75984)	77.00	90	3.0+T
	ENDOSCOPY			
	Surgical endoscopy always includes diagnostic endoscopy.			
47550	Biliary endoscopy, intraoperative(choledochoscopy) (List separately in addition to primary procedure)	54.00		
47552	Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with or without collection of specimen(s) by brushing and/or washing (separate procedure)	83.00		3.0+T
47553	with biopsy, single or multiple	117.00		3.0+T
47554	with removal of calculus/calculi	148.00		3.0+T
47555	with dilation of biliary duct stricture(s) without stent	114.00		3.0+T
	(For ERCP, see 43260-43272, 74363)			
47556	with dilation of biliary duct stricture(s) with stent	125.00		3.0+T
	(If imaging guidance is performed, see 74363, 75982)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	LAPAROSCOPY			
	Surgical laparoscopy always includes diagnostic laparoscopy.			
	To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.			
47560	Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy	85.00		3.0+T
47561	with guided transhepatic cholangiography with biopsy	104.00		3.0+T
47562	cholecystectomy	222.00	90	3.0+T
47563	cholecystectomy with cholangiography	237.00	90	3.0+T
47564	cholecystectomy with exploration of common duct	274.00	90	3.0+T
47570	cholecystoenterostomy	250.00	90	3.0+T
47579	Unlisted laparoscopy procedure, biliary tract	BR		3.0+T
	EXCISION			
47600	Cholecystectomy;	240.00	45	5.0+T
47605	with cholangiography	270.00	45	5.0+T
	(For laparoscopic approach, see 47562-47564)			
47610	Cholecystectomy with exploration of common duct;	280.00	45	5.0+T
47612	with choledochoenterostomy	330.00	45	5.0+T
47620	with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography	340.00	60	6.0+T
47630	Biliary duct stone extraction, percutaneous via T-tube tract, basket or snare (eg, Burhenne technique)	60.00	7	3.0+T
	(For radiological supervision and interpretation, see 74327)			
47700	Exploration for congenital atresia of bile ducts, without repair, with or without liver biopsy, with or without cholangiography	200.00	60	7.0+T
47701	Portoenterostomy (eg, Kasai procedure)	391.00	90	7.0+T
	(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	351.00	90	7.0+T
47712	intraphepatic	411.00	90	7.0+T
47715	Excision of choledochal cyst	266.00	90	7.0+T
47716	Anastomosis, choledochal cyst, without excision	224.00	90	7.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	REPAIR			
47720	Cholecystoenterostomy; direct (For laparoscopic approach, use 47570)	240.00	60	5.0+T
47721	with gastroenterostomy	360.00	60	5.0+T
47740	Roux-en-Y	260.00	60	5.0+T
47741	Roux-en-Y with gastroenterostomy	361.00	90	5.0+T
47760	Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract	300.00	90	5.0+T
47765	Anastomosis, of intrahepatic ducts and gastrointestinal tract	230.00	60	5.0+T
47780	Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract	340.00	90	5.0+T
47785	Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal tract	432.00	90	5.0+T
47800	Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis	320.00	90	5.0+T
47801	Placement of choledochal stent	230.00	60	5.0+T
47802	U-tube hepaticoenterostomy	300.00	90	5.0+T
47900	Suture of extrahepatic biliary duct for pre-existing injury (separate procedure)	336.00	90	5.0+T
47999	Unlisted procedure, biliary tract	BR		3.0+T
	PANCREAS			
	(For peroral pancreatic endoscopic procedures, see 43260-43272)			
	INCISION			
48000	Placement of drains, peripancreatic, for acute pancreatitis;	200.00	60	6.0+T
48001	with cholecystostomy, gastrostomy, and jejunostomy	278.00	90	6.0+T
48005	Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis	314.00	90	6.0+T
48020	Removal of pancreatic calculus	280.00	60	6.0+T
	EXCISION			
48100	Biopsy of pancreas, open, (eg, fine needle aspiration, needle core biopsy, wedge biopsy)	160.00	60	6.0+T
48102	Biopsy of pancreas, percutaneous needle	77.00	10	3.0+T
	(For radiological supervision and interpretation, see 76003, 76360, 76393, 76942) (For fine needle aspiration, use 10022)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
48120	Excision of lesion of pancreas (eg, cyst, adenoma)	285.00	60	6.0+T
48140	Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy	320.00	90	6.0+T
48145	with pancreaticojejunostomy	480.00	90	6.0+T
48146	Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)	560.00	90	6.0+T
48148	Excision of ampulla of Vater	100.00	90	6.0+T
48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, cholecystoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy	560.00	90	6.0+T
48152	without pancreatojejunostomy	680.00	90	6.0+T
48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, cholecystoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy	735.00	90	6.0+T
48154	without pancreatojejunostomy	BR	90	6.0+T
48155	Pancreatectomy, total	560.00	90	6.0+T
48180	Pancreaticojejunostomy, side-to-side anastomosis, (Puestow-type operation)	320.00	90	6.0+T

INTRODUCTION

48400	Injection procedure for intraoperative pancreatography (List separately in addition to primary procedure) (For radiological supervision and interpretation, see 74300-74305)	35.00		

REPAIR

48500	Marsupialization of pancreatic cyst	240.00	60	6.0+T
48510	External drainage, pseudocyst of pancreas; open	220.00	60	4.0+T
48511	percutaneous	91.00		4.0+T
48520	Internal anastomosis of pancreatic cyst to gastrointestinal tract; direct	280.00	60	6.0+T
48540	Roux-en-y	320.00	60	6.0+T
48545	Pancreatorrhaphy for injury	262.00	90	6.0+T
48547	Duodenal exclusion with gastrojejunostomy for pancreatic injury	379.00	90	6.0+T

PANCREAS TRANSPLANTATION

48554	Transplantation of pancreatic allograft	550.00	90	6.0+T
48556	Removal of transplanted pancreatic allograft	275.00	90	6.0+T
48999	Unlisted procedure, pancreas	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	ABDOMEN, PERITONEUM, AND OMENTUM			
	INCISION			
	(To report wound exploration due to penetrating trauma without laparotomy, use 20102)			
49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)	160.00	45	4.0+T
49002	Reopening of recent laparotomy	160.00	45	4.0+T
	(To report re-exploration of hepatic wound for removal of packing, use 47362)			
49010	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)	130.00	45	4.0+T
49020	Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; open	214.00	45	4.0+T
	(For appendiceal abscess, see 44900)			
49021	percutaneous (For radiological supervision and interpretation, use 75989)	159.00	45	4.0+T
49040	Drainage of subdiaphragmatic or subphrenic abscess; open	200.00	45	5.0+T
49041	percutaneous (For radiological supervision and interpretation, use 75989)	104.00		5.0+T
49060	Drainage of retroperitoneal abscess; open	160.00	45	5.0+T
49061	percutaneous	99.00		5.0+T
	(For laparoscopic drainage, use 49323) (For radiological supervision and interpretation, use 75989)			
49062	Drainage of extraperitoneal lymphocele to peritoneal cavity, open	217.00	90	5.0+T
49080	Peritoneocentesis, abdominal paracentesis, or peritoneal lavage(diagnostic or therapeutic); initial	16.00		3.0+T
49081	subsequent	12.00		3.0+T
	(For fine needle aspiration, use 10021 or 10022) (If imaging guidance is performed, see 76360, 76942			
49085	Removal of peritoneal foreign body from peritoneal cavity	130.00	60	5.0+T
	(For lysis of intestinal adhesions, see 44005)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	EXCISION, DESTRUCTION			
49180	Biopsy, abdominal or retroperitoneal mass, percutaneous needle (If imaging guidance is performed, see 76003, 76360, 76393, 76942)	40.00	10	3.0+T
49200	Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas;	280.00	60	5.0+T
49201	extensive	325.00	60	5.0+T
49215	Excision of presacral or sacrococcygeal tumor (Do not report modifier –63 in conjunction with 49215)	425.00	60	5.0+T
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)	BR		3.0+T
49250	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)	200.00	60	5.0+T
49255	Omentectomy, epiploectomy, resection of omentum (separate procedure)	200.00	60	5.0+T
	LAPAROSCOPY			
	Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy), (separate procedure), use 49320.			
	For laparoscopic fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface use 58662.			
49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	189.00	15	3.0+T
49321	Laparoscopy, surgical; with biopsy (single or multiple)	72.00	15	3.0+T
49322	with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)	72.00	15	3.0+T
49323	with drainage of lymphocele to peritoneal cavity	102.00	90	3.0+T
	(For percutaneous or open drainage, see 49060, 49061)			
49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum	BR		3.0+T
	INTRODUCTION, REVISION AND/OR REMOVAL			
49400	Injection of air or contrast into peritoneal cavity (separate procedure) (For radiological supervision and interpretation, see 74190)	16.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
49419	Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (ie, totally implantable)	120.00	21	4.0+T
	(For removal, use 49422)			
49420	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary	120.00	21	4.0+T
49421	permanent	120.00	21	4.0+T
49422	Removal of permanent intraperitoneal cannula or catheter	116.00	21	3.0+T
	(For removal of a temporary catheter/cannula, use appropriate E/M code)			
49423	Exchange of previously placed abcess or cyst drainage catheter under radiological guidance (separate procedure) (For radiological supervision and interpretation, use 75984)	16.00		3.0+T
49424	Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure) (For radiological supervision and interpretation, use 76080)	14.00		3.0+T
49425	Insertion of peritoneal-venous shunt	200.00	45	5.0+T
49426	Revision of peritoneal-venous shunt	161.00	45	5.0+T
	(For shunt patency test, see 78291)			
49427	Injection procedure (eg, contrast media) for evaluation of previously placed peritoneal-venous shunt (For radiological supervision and interpretation, see 75809, 78291)	14.00		3.0+T
49428	Ligation of peritoneal-venous shunt (For radiological supervision and interpretation, see 75809)	35.00	21	3.0+T
49429	Removal of peritoneal-venous shunt	112.00	21	3.0+T

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.

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

The excision/repair of strangulated organs or structures such as testicle(s), intestine, ovaries are reported by using the appropriate code for the excision/repair (eg, 44120, 54520, and 58940) in addition to the appropriate code for the repair of the strangulated hernia.

(To report bilateral hernia repair, use modifier -50)

(For reduction and repair of intra-abdominal hernia, see 44050)

(For debridement of abdominal wall, see 11042, 11043)

(Do not report modifier –63 in conjunction with 49491, 49492, 49495, 49496)

49491	Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks post-conception age, with or without hydrocelectomy; reducible	191.00	45	3.0+T
49492	incarcerated or strangulated	235.00	45	3.0+T

(Post-conception age equals gestational age at birth plus age of infant in weeks at the time of the hernia repair. Initial inguinal hernia repairs that are performed on preterm infants who are over 50 weeks post-conception age and under 6 monthsof age at the time of surgery, should be reported using codes 49495, 49496)

49495	Repair initial inguinal hernia, full term infant under age 6 months, or preterm infant over 50 weeks post-conception age and under age 6 months at the time of surgery, with or without hydrocelectomy; reducible	140.00	45	3.0+T
49496	incarcerated or strangulated	180.00	45	3.0+T

(Post-conceptual age equals gestational age at birth plus age in weeks at the time of the hernia repair. Initial inguinal hernia repairs that are performed on preterm infants who are under or up to 50 weeks post-conceptual age but under 6 months of age since birth, should be reported using codes 49491, 49492. Inguinal hernia repairs on infants age 6 months to under 5 years should be reported using codes 49500-49501)

49500	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; reducible	140.00	45	3.0+T
49501	incarcerated or strangulated	180.00	45	3.0+T
49505	Repair initial inguinal hernia, age 5 years or over; reducible	140.00	45	3.0+T
49507	incarcerated or strangulated	180.00	45	3.0+T
49520	Repair recurrent inguinal hernia, any age; reducible	160.00	45	3.0+T
49521	incarcerated or strangulated	180.00	45	3.0+T
49525	Repair inguinal hernia, sliding, any age	140.00	45	3.0+T
49540	Repair lumbar hernia	170.00	45	3.0+T
49550	Repair initial femoral hernia, any age; reducible	140.00	45	3.0+T
49553	incarcerated or strangulated	180.00	45	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
49555	Repair recurrent femoral hernia; reducible	180.00	45	3.0+T
49557	incarcerated or strangulated	180.00	45	3.0+T
49560	Repair initial incisional or ventral hernia; reducible	180.00	45	3.0+T
49561	incarcerated or strangulated	180.00	45	3.0+T
49565	Repair recurrent incisional or ventral hernia; reducible	180.00	45	3.0+T
49566	incarcerated or strangulated	180.00	45	3.0+T
49568	Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair)	87.00		
49570	Repair epigastric hernia (eg. preperitoneal fat); reducible (separate procedure);	140.00	45	3.0+T
49572	incarcerated or strangulated	180.00	45	3.0+T
49580	Repair umbilical hernia, under age 5 years; reducible	120.00	45	3.0+T
49582	incarcerated or strangulated	180.00	45	3.0+T
49585	Repair umbilical hernia, age 5 years or over; reducible	140.00	45	3.0+T
49587	incarcerated or strangulated	180.00	45	3.0+T
49590	Repair spigelian hernia (Do not report modifier –63 in conjunction with 49600-49611)	150.00	45	3.0+T
49600	Repair of small omphalocele, with primary closure	160.00	45	6.0+T
49605	Repair of large omphalocele or gastroschisis; with or without prosthesis	250.00	45	6.0+T
49606	with removal of prosthesis, final reduction and closure, in operating room	200.00	45	6.0+T
49610	Repair of omphalocele (Gross type operation); first stage	200.00	45	6.0+T
49611	second stage	200.00	60	6.0+T

(For diaphragmatic or hiatal hernia repair, see 39502-39541)

LAPAROSCOPY

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

49650	Laparoscopy, surgical; repair initial inguinal hernia	126.00	90	3.0+T
49651	repair recurrent inguinal hernia	154.00	90	3.0+T
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	BR		3.0+T

SUTURE

(For suture of ruptured diaphragm, see 39540, 39541)

(For debridement of abdominal wall, see 11042, 11043)

49900	Suture, secondary, of abdominal wall for evisceration or dehiscence	80.00	30	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	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)	407.00	90	4.0+T
49905	Omental flap, intra-abdominal (List separately in addition to primary procedure) (Do not report 49905 in conjunction with 47700)	102.00		
49906	Free omental flap with microvascular anastomosis (Do not report code 69990 in addition to code 49906)	250.00	30	6.0+T
49999	Unlisted procedure, abdomen, peritoneum and omentum	BR		4.0+T
	URINARY SYSTEM			
	KIDNEY			
	INCISION			
	(For retroperitoneal exploration, abscess, tumor, or cyst, see 49010, 49060, 49200, 49201)			
50010	Renal exploration, not necessitating other specific procedures	260.00	90	5.0+T
	(For laparoscopic ablation of renal mass lesion(s), use 50542)			
50020	Drainage of perirenal or renal abscess; open	200.00	90	5.0+T
50021	percutaneous	140.00		5.0+T
	(For radiological supervision and interpretation, use 75989)			
50040	Nephrostomy, nephrotomy with drainage	320.00	90	5.0+T
50045	Nephrotomy, with exploration	320.00	90	5.0+T
	(For renal endoscopy performed with nephrotomy, see 50570-50580)			
50060	Nephrolithotomy; removal of calculus	320.00	90	5.0+T
50065	secondary surgical operation for calculus	360.00	90	5.0+T
50070	complicated by congenital kidney abnormality	360.00	90	5.0+T
50075	removal of large staghorn calculus filling renal pelvis and calyces (including anatrophic pyelolithotomy)	360.00	90	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
50080	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting or basket extraction; up to 2 cm	280.00	90	3.0+T
50081	over 2 cm	400.00	90	3.0+T
	(For establishment of nephrostomy without nephrostolithotomy, see 50040, 50395 or 52334)			
	(For flourocopic guidance, see 76000-76001)			
50100	Transection or repositioning of aberrant renal vessels (separate procedure)	280.00	90	5.0+T
50120	Pyelotomy; with exploration	280.00	90	5.0+T
50125	with drainage, pyelostomy	280.00	90	5.0+T
50130	with removal of calculus (pyelolithotomy, pelviolithotomy, including coagulum pyelolithotomy)	280.00	90	5.0+T
50135	complicated (eg, secondary operation, congenital kidney abnormality)	365.00	90	5.0+T
	(For renal endoscopy performed in conjunction with pyelotomy, see 50570-50580)			

EXCISION

(For excision of retroperitoneal tumor or cyst, see 49200, 49201; for laparoscopic ablation of renal mass lesion(s), use 50542)

50200	Renal biopsy; percutaneous, by trocar or needle	20.00		3.0+T
	(For fine needle aspiration, use 10022)			
	(For radiological supervision and interpretation, see 76003, 76360, 76393, 76942)			
50205	by surgical exposure of kidney	200.00	90	5.0+T
50220	Nephrectomy, including partial ureterectomy, any open approach including rib resection;	320.00	90	5.0+T
50225	complicated because of previous surgery on same kidney	365.00	90	5.0+T
50230	radical, with regional lymphadenectomy and/or vena caval thrombectomy	390.00	90	5.0+T
	(When vena caval resection with reconstruction is necessary use 37799)			
50234	Nephrectomy with total ureterectomy and bladder cuff; through same incision	400.00	90	5.0+T
50236	through separate incision	400.00	90	5.0+T
50240	Nephrectomy, partial	400.00	90	5.0+T
	(For laparoscopic partial nephrectomy, use 50543)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
50250	Ablation, open, one or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound, if performed	375.00	90	5.0+T
50280	Excision or unroofing of cyst(s)of kidney	280.00	90	5.0+T
	(For laparoscopic ablation of renal cysts, use 50541)			
50290	Excision of perinephric cyst	280.00	60	5.0+T
	RENAL TRANSPLANTATION			
	(For dialysis, see 90935-90999)			
	(For laparoscopy donor nephrectomy, use 50547)			
	(For laparoscopic drainage of lymphocele to peritoneal cavity, use 49323)			
50320	Donor nephrectomy (including cold preservation); open, from living donor	320.00	90	5.0+T
50340	Recipient nephrectomy (separate procedure)	320.00	90	5.0+T
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	500.00	90	5.0+T
50365	with recipient nephrectomy	660.00	90	5.0+T
50370	Removal of transplanted renal allograft	320.00	90	5.0+T
50380	Renal autotransplantation, reimplantation of kidney	500.00	90	5.0+T
	INTRODUCTION			
50382	Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation	442.00		5.0+T
50384	Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation	427.00		5.0+T
50387	Removal and replacement of externally accessible transnephric ureteral stent (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation	214.00		5.0+T
50389	Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent)	146.00		5.0+T
50390	Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous (For radiological supervision and interpretation, see 74425, 74470, 76003, 76360, 76393, 76942)	20.00		3.0+T
50391	Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent)	26.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous (For radiological supervision and interpretation, see 74475, 76360, 76942)	36.00	30	5.0+T
50393	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous (For radiological supervision and interpretation, see 74480, 76003, 76360, 76942)	65.00	30	5.0+T
50394	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (For radiological supervision and interpretation, see 74425)	4.00		3.0+T
50395	Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous (For radiological supervision and interpretation, see 74475, 74480, 74485) (For nephrostolithotomy, see 50080, 50081) (For retrograde percutaneous nephrostomy, see 52334) (For endoscopic surgery, see 50551-50561)	55.00	30	3.0+T
50396	Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (For radiological supervision and interpretation, see 74425, 74475, 74480)	5.00		3.0+T
50398	Change of nephrostomy or pyelostomy tube (For radiological supervision and interpretation, see 75984) (For fluoroscopic guidance, see 76000)	4.00		3.0+T
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	320.00	90	5.0+T
50405	complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calycoplasty) (For laparoscopic approach, use 50544)	320.00	90	5.0+T
50500	Nephrorrhaphy, suture of kidney wound or injury	320.00	90	5.0+T
50520	Closure of nephrocutaneous or pyelocutaneous fistula	320.00	90	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
50525	Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; abdominal approach	320.00	90	5.0+T
50526	thoracic approach	320.00	90	5.0+T
50540	Symphysiotomy for horseshoe kidney with or without pyeloplasty and/or other plastic procedure, unilateral or bilateral (one operation)	400.00	90	5.0+T

LAPAROSCOPY

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

50541	Laparoscopy, surgical; ablation of renal cysts	172.00	90	5.0+T
50542	ablation of renal mass lesion(s)	172.00	90	5.0+T
50543	partial nephrectomy (For open procedure, see 50220-50240)	200.00	90	5.0+T
50544	pyelopasty	241.00	90	5.0+T
50545	radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy) (For open procedure, use 50230)	258.00	90	5.0+T
50546	nephrectomy, including partial ureterectomy	220.00	90	5.0+T
50547	donor nephrectomy (including cold preservation), from living donor (For open procedure, use 50320)	274.00	90	5.0+T
50548	nephrectomy with total ureterectomy (For open procedure, see 50234, 50236)	262.00	90	5.0+T
50549	Unlisted lapaoscopy procedure, renal	BR		5.0+T

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

ENDOSCOPY

50551	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	17.00	7	3.0+T
50553	with ureteral catheterization, with or without dilation of ureter	23.00	7	3.0+T
50555	with biopsy	23.00	7	3.0+T
50557	with fulguration and/or incision, with or without biopsy	26.00	7	3.0+T
50561	with removal of foreign body or calculus	26.00	7	3.0+T
50562	with resection of tumor	170.00	7	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	(When procedures 50570-50580 provide a significant identifiable service, they may be added to 50045 and 50120)			
50570	Renal endoscopy through nephrotomy or pyelotomy, irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	18.00	7	3.0+T
50572	with ureteral catheterization, with or without dilation of ureter	23.00	7	3.0+T
50574	with biopsy	23.00	7	3.0+T
50575	with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent)	270.00	7	3.0+T
50576	with fulguration and/or incision, with or without biopsy	26.00	7	3.0+T
50580	with removal of foreign body or calculus	26.00	7	3.0+T
	(For nephrotomy, see 50045) (For pyelotomy, see 50120)			
	OTHER PROCEDURES			
50590	Lithotripsy, extracorporeal shock wave	223.00		3.0+T
50592	Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency	BR	10	3.0+T
	URETER			
	INCISION			
50600	Ureterotomy with exploration or drainage (separate procedure)	280.00	90	5.0+T
	(For ureteral endoscopy performed with ureterotomy, see 50970-50980)			
50605	Ureterotomy for insertion of indwelling stent, all types	270.00	90	5.0+T
50610	Ureterolithotomy; upper one-third of ureter	280.00	90	5.0+T
50620	middle one-third of ureter	280.00	90	5.0+T
50630	lower one-third of ureter	320.00	90	5.0+T
	(For laparoscopic approach, use 50945) (For transvesical ureterolithotomy, see 51060) (For cystotomy with stone basket extraction of ureteral calculus, see 51065) (For endoscopic extraction or manipulation of ureteral calculus, see 50080, 50081, 50561, 50961, 50980, 52320-52330, 52352, 52353)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	EXCISION			
	(For ureterocele, see 51535, 52300)			
50650	Ureterectomy, with bladder cuff (separate procedure)	320.00	90	5.0+T
50660	Ureterectomy, total, ectopic ureter, combination abdominal, vaginal and/or perineal approach	320.00	90	5.0+T
	INTRODUCTION			
	(For radiological supervision and interpretation, see 74425)			
50684	Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter	4.00		3.0+T
50686	Manometric studies through ureterostomy or indwelling ureteral catheter	5.00		3.0+T
50688	Change of ureterostomy tube or externally accessible ureteral stend via ileal conduit	4.00		3.0+T
	(If imaging guidance is performed, use 75984)			
50690	Injection procedure for visualization of ileal conduit and/or ureteropyelography, exclusive of radiologic service	5.00		3.0+T
	REPAIR			
50700	Ureteroplasty, plastic operation on ureter (eg, stricture)	320.00	90	5.0+T
50715	Ureterolysis, with or without epositioning of ureter for retroperitoneal fibrosis	280.00	90	5.0+T
50722	Ureterolysis for ovarian vein syndrome	280.00	90	5.0+T
50725	Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava	390.00	90	5.0+T
50727	Revision of urinary-cutaneous anastomosis (any type urostomy);	149.00	90	5.0+T
50728	with repair of fascial defect and hernia	218.00	90	5.0+T
50740	Ureteropyelostomy, anastomosis of ureter and renal pelvis	320.00	90	5.0+T
50750	Ureterocalycostomy, anastomosis of ureter to renal calyx	320.00	90	5.0+T
50760	Ureteroureterostomy	320.00	90	5.0+T
50770	Transureteroureterostomy, anastomosis of ureter to contralateral ureter	320.00	90	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	(Codes 50780-50785 include minor procedures to prevent vesicoureteral reflux)			
50780	Ureteroneocystostomy; anastomosis of single ureter to bladder	356.00	90	5.0+T
	(When combined with cystourethroplasty or vesical neck revision, see 51820)			
50782	anastomosis of duplicated ureter to bladder	369.00	90	5.0+T
50783	with extensive ureteral tailoring	379.00	90	5.0+T
50785	with vesico-psoas hitch or bladder flap	400.00	90	5.0+T
50800	Ureteroenterostomy, direct anastomosis of ureter to intestine	320.00	90	5.0+T
50810	Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis	455.00	90	5.0+T
50815	Ureterocolon conduit, including intestine anastomosis	448.00	90	5.0+T
50820	Ureteroileal conduit (ileal bladder), including intestine anastomosis (Bricker operation)	455.00	90	5.0+T
	(For combination of 50800-50820 with cystectomy, see 51580-51595)			
50825	Continent diversion, including intestine anastomosis using any segment of small and/or large bowel (Kock pouch or Camey enterocystoplasty)	600.00	90	5.0+T
50830	Urinary undiversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroenterostomy with uretero-ureterostomy or ureteroneocystostomy)	360.00	90	5.0+T
50840	Replacement of all or part of ureter by intestine segment, including intestine anastomosis	455.00	90	5.0+T
50845	Cutaneous appendico-vesicostomy	378.00	90	5.0+T
50860	Ureterostomy, transplantation of ureter to skin	280.00	90	5.0+T
50900	Ureterorrhaphy, suture of ureter (separate procedure)	320.00	90	5.0+T
50920	Closure of ureterocutaneous fistula	320.00	90	5.0+T
50930	Closure of ureterovisceral fistula (including visceral repair)	320.00	90	5.0+T
50940	Delegation of ureter	300.00	90	5.0+T
	(For ureteroplasty, ureteroylysis, see 50700-50860)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	LAPAROSCOPY			
	Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy), (separate procedure), use 49320.			
50945	Laparoscopy, surgical; ureterolithotomy	183.00	90	5.0+T
50947	ureteroneocystostomy with cystoscopy and ureteral stent placement	263.00	90	5.0+T
50948	ureteroneocystostomy without cystoscopy and ureteral stent placement	242.00	90	5.0+T
	(For open ureteroneocystostomy, see 50780-50785)			
50949	Unlisted laparoscopic procedure, ureter	BR		5.0+T
	ENDOSCOPY			
50951	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	17.00	7	3.0+T
50953	with ureteral catheterization, with or without dilation of ureter	23.00	7	3.0+T
50955	with biopsy	23.00	7	3.0+T
50957	with fulguration and/or incision, with or without biopsy	26.00	7	3.0+T
50961	with removal of foreign body or calculus	26.00	7	3.0+T
	(When procedures 50970-50980 provide a significant identifiable service, they may be added to 50600)			
50970	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	17.00	7	3.0+T
	(For ureterotomy, use 50600)			
50972	with ureteral catheterization, with or without dilation of ureter	23.00	7	3.0+T
50974	with biopsy	23.00	7	3.0+T
50976	with fulguration and/or incision, with or without biopsy	26.00	7	3.0+T
50980	Ureteral endoscopy through ureterotomy, or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	26.00	7	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

BLADDER

INCISION

51000	Aspiration of bladder; by needle	20.00		3.0+T
51005	by trocar or intracatheter	20.00		3.0+T
51010	with insertion of suprapubic catheter	40.00	30	3.0+T
	(If imaging guidance is performed, see 76003, 76360, 76942)			
51020	Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material	240.00	90	5.0+T
51030	with cryosurgical destruction of intravesical lesion	240.00	90	5.0+T
51040	Cystostomy, cystotomy with drainage	200.00	90	5.0+T
51045	Cystotomy, with insertion of ureteral catheter or stent (separate procedure)	165.00	90	5.0+T
51050	Cystolithotomy, cystotomy with removal of calculus, without vesical neck resection	200.00	90	5.0+T
51060	Transvesical ureterolithotomy	275.00	90	5.0+T
51065	Cystotomy, with calculus basket extraction and/or ultrasonic or electrohydraulic fragmentation of ureteral calculus	185.00	90	5.0+T
51080	Drainage of perivesical or prevesical space abscess	200.00	90	5.0+T

EXCISION

51500	Excision of urachal cyst or sinus, with or without umbilical hernia repair	215.00	90	5.0+T
51520	Cystotomy; for simple excision of vesical neck (separate procedure)	240.00	90	5.0+T
51525	for excision of bladder diverticulum, single or multiple (separate procedure)	280.00	90	5.0+T
51530	for excision of bladder tumor	240.00	90	5.0+T
	(For transurethral resection, see 52234-52240, 52305) (For transurethra excision, see 52300)			
51535	Cystotomy for excision, incision, or repair of ureterocele	240.00	90	5.0+T
51550	Cystectomy, partial; simple	280.00	90	6.0+T
51555	complicated (eg, postradiation, previous surgery, difficult location)	300.00	90	6.0+T
51565	Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)	320.00	90	6.0+T
51570	Cystectomy, complete; (separate procedure)	400.00	90	6.0+T
51575	with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	520.00	90	6.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
51580	Cystectomy, complete with ureterosigmoidostomy or ureterocutaneous transplantations;	520.00	90	6.0+T
51585	with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	650.00	90	7.0+T
51590	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis;	675.00	90	7.0+T
51595	with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	780.00	90	7.0+T
51596	Cystectomy, complete, with continent diversion, any technique, using any segment of small and/or large intestine to construct neobladder	820.00	90	7.0+T
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	800.00	90	15.0+T
	(For pelvic exenteration for gynecologic malignancy, use 58240)			

INTRODUCTION

(For bladder catheterization, complicated, see 53675)

51600	Injection procedure for cystography or voiding urethrocystography	4.00		3.0+T
51605	Injection procedure and placement of chain for contrast and/or chain urethrocystography (For radiological supervision and interpretation, see 74430, 74455)	5.00		3.0+T
51610	Injection procedure for retrograde urethrocystography (For radiological supervision and interpretation, see 74450)	4.00		3.0+T
51700	Bladder irrigation, simple, lavage and/or instillation	4.00		3.0+T
	(Code 51703 is reported only when performed independently. Do not report 51703 when catheter insertion is an inclusive component of another procedure)			
51703	Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)	20.00		3.0+T
51710	Change of cystostomy tube; complicated	30.00		3.0+T
	(If imaging guidance is performed, use 75984)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	72.00		3.0+T
51720	Bladder instillation of anticarcinogenic agent (including detention time)	4.00		3.0+T
L8603	Collagen implant, urinary tract, per 2.5 cc syringe	BR		

URODYNAMICS

The following section (51725-51797) 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.

51725	Simple cystometrogram (CMG) (eg, spinal manometer)	10.00		
51726	Complex cystometrogram (eg, calibrated electronic equipment)	10.00		
51736	Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)	4.00		
51741	Complex uroflowmetry (eg, calibrated electronic equipment)	4.00		
51772	Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique	15.00		
51784	Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique	15.00		
51785	Needle electromyography studies (EMG) of anal or urethral sphincter, any technique	15.00		
51792	Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)	15.00		
51795	Voiding pressure studies (VP); bladder voiding pressure, any technique	25.00		
51797	intra-abdominal voiding pressure (AP)(rectal, gastric, intraperitoneal)	25.00		
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	6.00		

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	320.00	90	5.0+T
51820	Cystourethroplasty with unilateral or bilateral ureteroneocystostomy	455.00	90	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
51840	Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz, Burch); simple	160.00	45	4.0+T
51841	complicated (eg, secondary repair)	275.00	45	4.0+T
	(For urethropexy (Pereyra type), see 57289)			
51845	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)	190.00	45	4.0+T
51860	Cystorrhaphy, suture of bladder wound, injury or rupture; simple	240.00	90	6.0+T
51865	complicated	300.00	90	6.0+T
51880	Closure of cystostomy (separate procedure)	120.00	90	3.0+T
51900	Closure of vesicovaginal fistula, abdominal approach	240.00	90	5.0+T
	(For closure of vesicovaginal fistula, vaginal approach, see 57320-57330)			
51920	Closure of vesicouterine fistula;	240.00	90	5.0+T
51925	with hysterectomy (See Rule 14)	360.00	90	5.0+T
	(For closure of vesicoenteric fistula, see 44660, 44661) (For closure of rectovesical fistula, see 45800-45805)			
51940	Closure, exstrophy of bladder (see also 54390)	320.00	180	5.0+T
51960	Enterocystoplasty, including intestinal anastomosis	455.00	90	5.0+T
51980	Cutaneous vesicostomy	300.00	90	5.0+T

LAPAROSCOPY

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

51990	Laparoscopy, surgical; urethral suspension for stress incontinence	134.00	90	5.0+T
51992	sling operation for stress incontinence (eg, fascia or synthetic)	151.00	90	5.0+T
	(For open sling operation for stress incontinence, use 57288) (For reversal or removal of sling operation for stress incontinence, use 57287)			
51999	Unlisted laparoscopy procedure, bladder	BR		5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

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)	17.00	7	3.0+T
52001	Cystourethroscopy with irrigation and evacuation of multiple obstructing clots (Do not report 52001 in addition to 52000)	39.00	7	3.0+T
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	60.00	7	3.0+T
52007	with brush biopsy of ureter and/or renal pelvis	80.00	7	3.0+T
52010	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service (For radiological supervision and interpretation, see 74440)	60.00	7	3.0+T

TRANSURETHRAL SURGERY

URETHRA AND BLADDER

52204	Cystourethroscopy, with biopsy	40.00	7	3.0+T
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	40.00	7	3.0+T
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s), with or without biopsy	40.00	7	3.0+T
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)	40.00	7	3.0+T
52235	MEDIUM bladder tumor(s)(2.0 to 5.0 cm)	100.00	30	3.0+T
52240	LARGE bladder tumor(s)	240.00	90	5.0+T
52250	Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration	120.00	30	3.0+T
52260	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	60.00	30	3.0+T
52265	local anesthesia	60.00	30	3.0+T
52270	Cystourethroscopy, with internal urethrotomy; female	80.00	45	3.0+T
52275	male	80.00	45	3.0+T
52276	Cystourethroscopy, with direct vision internal urethrotomy	80.00	45	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
52277	Cystourethroscopy, with resection of external sphincter (sphincterotomy)	90.00	45	3.0+T
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	30.00	45	3.0+T
52282	Cystourethroscopy, with insertion of urethral stent	69.00	7	3.0+T
52283	Cystourethroscopy, with steroid injection into stricture	26.00	7	3.0+T
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	45.00	7	3.0+T
52290	Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral	80.00	30	3.0+T
52300	with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral	80.00	30	3.0+T
52301	with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral	100.00	30	3.0+T
52305	with incision or resection of orifice of bladder diverticulum, single or multiple	80.00	30	3.0+T
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple	80.00	30	3.0+T
52315	complicated	145.00	30	3.0+T
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)	200.00	90	3.0+T
52318	complicated or large (over 2.5 cm)	250.00	90	3.0+T

URETER AND PELVIS

Surgical cystorethroscopy always includes diagnostic cystourethroscopy. To report a diagnostic cystorethroscopy, use 52351.

Do not report 52351 in conjunction with 52341-52346, 52352-52355.

The insertion and removal of a temporary stent during diagnostic or therapeutic cystourethroscopic intervention(s) is included in 52320-52355 and should not be reported separately.

To report insertion of a self-retaining, indwelling stent performed during cystourethroscopic diagnostic or therapeutic intervention(s), use code 52332, in addition to primary procedure(s) performed. Code 52332 is used to report a unilateral procedure unless otherwise specified. For bilateral insertion of self-retaining, indwelling ureteral stents, use code 52332, and append the Modifier '50. To report cystourethroscopic removal of a self-retaining, indwelling ureteral stent, see codes 52310, 52315.

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
52320	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus	120.00	30	3.0+T
52325	with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)	149.00	30	3.0+T
52327	with subureteric injection of implant material	56.00		3.0+T
52330	with manipulation, without removal of ureteral calculus	80.00	7	3.0+T
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double- J type)	68.00	30	3.0+T
52334	Cystourethroscopy, with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde (For percutaneous nephrostolithotomy, see 50080, 50081) (For establishment of nephrostomy tract only, see 50395)	91.00	30	3.0+T
52341	Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	65.00		3.0+T
52342	with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	70.00		3.0+T
52343	with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	77.00		3.0+T
52344	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	83.00		3.0+T
52345	with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	88.00		3.0+T
52346	with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	121.00	7	3.0+T
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic (For radiological supervision and interpretation, use 74485) (Do not report 52351 in conjunction with 52341-52346, 52352-52355)	121.00		3.0+T
52352	with removal or manipulation of calculus (ureteral catheterization is included)	199.00	30	3.0+T
52353	with lithotripsy (ureteral catheterization is included)	220.00	90	5.0+T
52354	with biopsy and/or fulguration of ureteral or renal pelvic lesion	152.00	90	5.0+T
52355	with resection of ureteral or renal pelvic tumor	169.00	90	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
VESICAL NECK AND PROSTATE				
52400	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	104.00	90	5.0+T
52402	Cystourethroscopy with transurethral resection or incision of ejaculatory ducts	83.00		3.0+T
52450	Transurethral incision of prostate	160.00	90	5.0+T
52500	Transurethral resection of bladder neck (separate procedure)	200.00	90	4.0+T
52510	Transurethral balloon dilation of the prostatic urethra	20.00		3.0+T
52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included) (For other approaches, see 55801-55845)	320.00	90	5.0+T
52606	Transurethral fulguration for postoperative bleeding occurring after the usual follow-up time	30.00	15	3.0+T
52612	Transurethral resection of prostate; first stage of two-stage resection (partial resection)	140.00	90	5.0+T
52614	second stage of two-stage resection (resection completed)	140.00	90	5.0+T
52620	Transurethral resection; of residual obstructive tissue after 90 days postoperative	90.00	90	5.0+T
52630	of regrowth of obstructive tissue longer than one year postoperative	320.00	90	5.0+T
52640	of postoperative bladder neck contracture	150.00	90	5.0+T
52647	Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)	220.00	90	5.0+T
52648	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	233.00	90	5.0+T
52700	Transurethral drainage of prostatic abscess	120.00	60	4.0+T

URETHRA

(For endoscopy, see cystoscopy, urethroscopy, cystourethroscopy,52000-52700)
(For injection procedure for urethrocystography, see 51600-51610)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
INCISION				
53000	Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra	40.00	15	3.0+T
53010	perineal urethra, external	100.00	15	3.0+T
53020	Meatotomy, cutting of meatus (separate procedure); except infant	12.00	7	3.0+T
53025	infant	12.00	7	3.0+T
	(Do not report modifier -63 in conjunction with 53025)			
53040	Drainage of deep periurethral abscess	40.00	30	3.0+T
	(For subcutaneous abscess, see 10060, 10061)			
53060	Drainage of Skene's gland abscess or cyst	20.00	15	3.0+T
53080	Drainage of perineal urinary extravasation; uncomplicated(separate procedure)	60.00	15	3.0+T
53085	complicated	200.00	60	5.0+T
EXCISION				
53200	Biopsy of urethra	30.00	15	3.0+T
53210	Urethrectomy, total, including cystostomy; female	215.00	60	3.0+T
53215	male	270.00	60	3.0+T
53220	Excision or fulguration of carcinoma of urethra	90.00	7	3.0+T
53230	Excision of urethral diverticulum (separate procedure); female	200.00	60	3.0+T
53235	male	200.00	60	3.0+T
53240	Marsupialization of urethral diverticulum, male or female	60.00	15	3.0+T
53250	Excision of bulbourethral gland (Cowper's gland)	185.00	60	5.0+T
53260	Excision or fulguration; urethral polyp(s), distal urethra	20.00	15	3.0+T
	(For endoscopic approach, see 52214, 52224)			
53265	urethral caruncle	28.00	30	3.0+T
53270	Skene's glands	28.00	30	3.0+T
53275	urethral prolapse	60.00	60	3.0+T
REPAIR				
	(For hypospadias, see 54300-54352)			
53400	Urethroplasty; first stage, for fistula, diverticulum, or stricture, (eg, Johannsen type)	160.00	60	3.0+T
53405	second stage (formation of urethra), including urinary diversion	210.00	60	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
53410	Urethroplasty, one-stage reconstruction of male anterior urethra	240.00	60	3.0+T
53415	Urethroplasty, transpubic or perineal, one stage, for reconstruction or repair of prostatic or membranous urethra	340.00	60	3.0+T
53420	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage	300.00	90	5.0+T
53425	second stage	300.00	90	5.0+T
53430	Urethroplasty, reconstruction of female urethra	160.00	60	3.0+T
53431	Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg, Tenago, Leadbetter procedure)	313.00	60	3.0+T
53440	Sling operation for correction of male urinary incontinence, (eg, fascia or synthetic)	300.00	90	5.0+T
53442	Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)	BR		3.0+T
53444	Insertion of tandem cuff (dual cuff)	224.00	60	3.0+T
53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff	275.00	60	3.0+T
53446	Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff	207.00	60	3.0+T
53447	Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir and cuff at the same operative session	238.00	60	3.0+T
53448	Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue (Do not report 11040-11043 in addition to 53448)	375.00	60	3.0+T
53449	Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff	BR		3.0+T
53450	Urethromeatoplasty, with mucosal advancement (For meatotomy, see 53020-53025)	60.00	60	3.0+T
53460	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)	65.00	60	3.0+T
53500	Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring)	207.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
53502	Urethrorrhaphy, suture of urethral wound or injury; female	BR	60	4.0+T
53505	penile	150.00	60	4.0+T
53510	perineal	210.00	60	4.0+T
53515	prostatomembranous	300.00	60	4.0+T
53520	Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)	120.00	60	4.0+T
	(For closure of urethrovaginal fistula, see 7310) (For closure of urethrorectal fistula, see 45820, 45825)			

MANIPULATION

(For radiological supervision and interpretation, see 74485)

53600	Dilation of urethral stricture by passage of sound or urethral dilator, male; initial	12.00		3.0+T
53601	subsequent	6.00		3.0+T
53605	Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction(spinal) anesthesia	20.00		3.0+T
53620	Dilation of urethral stricture by passage of filiform and follower, male; initial	20.00		3.0+T
53621	subsequent	10.00		3.0+T
53660	Dilation of female urethra including suppository and/or instillation; initial	8.00		3.0+T
53661	subsequent	4.00		3.0+T
53665	Dilation of female urethra, general or conduction (spinal) anesthesia	12.00		3.0+T

OTHER PROCEDURES

53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	180.00	30	3.0+T
53852	by radiofrequency thermotherapy	180.00	30	3.0+T
53853	by water-induced thermotherapy	180.00	30	3.0+T
53899	Unlisted procedure, urinary system	BR		3.0+T

MALE GENITAL SYSTEM

PENIS

INCISION

54000	Slitting of prepuce, dorsal or lateral (separate procedure); newborn (Do not report modifier –63 in conjunction with 54000)	12.00		3.0+T
54001	except newborn	12.00		3.0+T
54015	Incision and drainage of penis, deep	12.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	(For skin and subcutaneous abscess, see 10060-10160)			
DESTRUCTION				
54050	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	8.00		3.0+T
54055	electrodesiccation	8.00		3.0+T
54056	cryosurgery	8.00		3.0+T
54057	laser surgery	8.00		3.0+T
54060	surgical excision	20.00	30	3.0+T
54065	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive,(eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	BR		3.0+T
EXCISION				
54100	Biopsy of penis; (separate procedure)	12.00	15	3.0+T
54105	deep structures	12.00	15	3.0+T
54110	Excision of penile plaque (Peyronie disease);	140.00	60	3.0+T
54111	with graft to 5 cm in length	260.00	60	3.0+T
54112	with graft greater than 5 cm in length	300.00	60	3.0+T
54115	Removal foreign body from deep penile tissue (eg, plastic implant)	80.00	30	3.0+T
54120	Amputation of penis; partial	160.00	60	3.0+T
54125	complete	240.00	60	3.0+T
54130	Amputation of penis, radical; with bilateral inguinofemoral lymphadenectomy	400.00	90	4.0+T
54135	in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	520.00	90	4.0+T
	(For lymphadenectomy (separate procedure), see 38760-38770)			
54150	Circumcision, using clamp or other device; newborn (Do not report modifier -63 in conjunction with 54150)	12.00	15	3.0+T
54152	except newborn	20.00	15	3.0+T
54160	Circumcision, surgical excision other than clamp, device or dorsal slit; newborn (Do not report modifier -63 in conjunction with 54160)	40.00	30	3.0+T
54161	except newborn	40.00	30	3.0+T
54162	Lysis or excision of penile post-circumcision adhesions	65.00	30	3.0+T
54163	Repair incomplete circumcision	61.00	30	3.0+T
54164	Frenulotomy of penis (Do not report with circumcision codes 54150-54161, 54162, 54163)	54.00	30	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
INTRODUCTION				
54200	Injection procedure for Peyronie disease;	7.00		3.0+T
54205	with surgical exposure of plaque	140.00	60	3.0+T
54220	Irrigation of corpora cavernosa for priapism	26.00		3.0+T
54230	Injection procedure for corpora cavernosography (For radiological supervision and interpretation, see 74445)	5.00		3.0+T
54240	Penile plethysmography	25.00		3.0+T
54250	Nocturnal penile tumescence and/or rigidity test	55.00		3.0+T
REPAIR				
	(For other urethroplasties, see 53400-53430)			
	(For penile revascularization, see 37788)			
54300	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra	120.00	30	3.0+T
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	240.00	30	3.0+T
54308	Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm	230.00	30	3.0+T
54312	greater than 3 cm	260.00	30	3.0+T
54316	Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia	310.00	30	3.0+T
54318	Urethroplasty for third stage hypospadias repair to release penis from scrotum (eg, 3rd stage Cecil repair)	225.00	30	3.0+T
54322	One stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V-flap)	240.00	30	3.0+T
54324	with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap)	305.00	30	3.0+T
54326	with urethroplasty by local skin flaps and mobilization of urethra	285.00	30	3.0+T
54328	One stage distal hypospadias repair (with or without chordee or circumcision); with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap	285.00	30	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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	320.00	30	3.0+T
54336	One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap	410.00	30	3.0+T
54340	Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple	180.00	30	3.0+T
54344	requiring mobilization of skin flaps and urethroplasty with flap or patch graft	315.00	30	3.0+T
54348	requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)	320.00	30	3.0+T
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	440.00	30	3.0+T
54360	Plastic operation on penis to correct angulation	220.00	30	3.0+T
54380	Plastic operation on penis for epispadias distal to external sphincter;	200.00	30	4.0+T
54385	with incontinence	BR	30	4.0+T
54390	with exstrophy of bladder	480.00	30	4.0+T
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	200.00	30	4.0+T
54401	inflatable (self contained)	220.00	30	4.0+T
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	244.00	30	4.0+T
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis	204.00	30	4.0+T
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis	215.00	30	4.0+T
54410	Removal and replacement of all component(s)of a multi-component, inflatable penile prosthesis at the same operative session	254.00	30	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue (Do not report 11040-11043 in addition to 54411)	277.00	30	4.0+T
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis	152.00	30	4.0+T
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session	197.00	30	4.0+T
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue (Do not report 11040-11043 in addition to 54417)	243.00	30	4.0+T
54420	Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral	200.00	90	4.0+T
54430	Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilateral	200.00	90	4.0+T
54435	Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism	125.00	30	4.0+T
54440	Plastic operation of penis for injury	200.00	30	4.0+T
MANIPULATION				
54450	Foreskin manipulation including lysis of preputial adhesions and stretching	20.00	30	4.0+T
TESTIS				
EXCISION				
54500	Biopsy of testis, needle (separate procedure) (For fine needle aspiration, see 10021, 10022)	8.00	15	3.0+T
54505	Biopsy of testis, incisional (separate procedure) (When combined with vasogram, seminal vesiculogram, or epididymogram, use 55300)	40.00	15	3.0+T
54512	Excision of extraparenchymal lesion of testis	92.00	30	3.0+T
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	80.00	30	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
54522	Orchiectomy, partial	102.00	30	3.0+T
54530	Orchiectomy, radical, for tumor; inguinal approach	200.00	90	3.0+T
54535	with abdominal exploration	280.00	90	3.0+T
	(For orchiectomy with repair of hernia, see 49505 or 49507 and 54520) (For radical retroperitoneal lymphadenectomy, see 38780)			
54550	Exploration for undescended testis (inguinal or scrotal area)	160.00	30	3.0+T
54560	Exploration for undescended testis with abdominal exploration	200.00	30	3.0+T

REPAIR

54600	Reduction of torsion of testis, surgical, with or without fixation of contralateral testis	120.00	30	3.0+T
54620	Fixation of contralateral testis (separate procedure)	80.00	30	3.0+T
54640	Orchiopexy, inguinal approach, with or without hernia repair	200.00	60	3.0+T
	(For inguinal hernia repair performed in conjunction with inguinal orchiopexy, see 49495-49525)			
54650	Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens) (For laparoscopic approach, use 54692)	214.00	90	3.0+T
54660	Insertion of testicular prosthesis (separate procedure)	40.00	30	3.0+T
54670	Suture or repair of testicular injury	120.00	60	3.0+T
54680	Transplantation of testis(es) to thigh (because of scrotal destruction)	300.00	60	3.0+T

LAPAROSCOPY

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

54690	Laparoscopy, surgical; orchiectomy	118.00	30	3.0+T
54692	orchiopexy for intra-abdominal testis	138.00	30	3.0+T
54699	Unlisted laparoscopy procedure, testis	BR		3.0+T

EPIDIDYMIS

INCISION

54700	Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)	12.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	EXCISION			
54800	Biopsy of epididymis, needle	8.00	15	3.0+T
	(For fine needle aspiration, see 10021, 10022)			
54820	Exploration of epididymis, with or without biopsy	40.00	30	3.0+T
54830	Excision of local lesion of epididymis	90.00	90	3.0+T
54840	Excision of spermatocele, with or without epididymectomy	120.00	90	3.0+T
54860	Epididymectomy; unilateral	120.00	90	3.0+T
54861	bilateral	180.00	90	3.0+T
	TUNICA VAGINALIS			
	INCISION			
55000	Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication	8.00		3.0+T
	EXCISION			
55040	Excision of hydrocele; unilateral	120.00	90	3.0+T
55041	bilateral	180.00	90	3.0+T
	(With hernia repair, see 49495, 49501)			
	REPAIR			
55060	Repair of tunica vaginalis hydrocele (Bottle type)	80.00	90	3.0+T
	SCROTUM			
	INCISION			
55100	Drainage of scrotal wall abscess (see also 54700)	8.00		3.0+T
55110	Scrotal exploration	100.00	30	3.0+T
55120	Removal of foreign body in scrotum	40.00	30	3.0+T
	EXCISION			
	(For excision, local lesion of scrotum skin, see Integumentary System)			
55150	Resection of scrotum	100.00	30	3.0+T
	REPAIR			
55175	Scrotoplasty; simple	120.00	30	3.0+T
55180	complicated	180.00	30	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	VAS DEFERENS			
	INCISION			
55200	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)	60.00	30	3.0+T
	EXCISION			
55250	Vasectomy, unilateral or bilatera (separate procedure), including postoperative semen examination(s) (see Rule 13)	60.00	30	3.0+T
	REPAIR			
55400	Vasovasostomy, vasovasorrhaphy	120.00	30	3.0+T
	SUTURE			
55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure) (see Rule 13)	20.00	30	3.0+T
	SPERMATIC CORD			
	EXCISION			
55500	Excision of hydrocele of spermatic cord, unilateral (separate procedure)	120.00	90	3.0+T
55520	Excision of lesion of spermatic cord (separate procedure)	120.00	90	3.0+T
55530	Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)	120.00	45	3.0+T
55535	abdominal approach	160.00	45	3.0+T
55540	with hernia repair	160.00	45	3.0+T
	LAPAROSCOPY			
	Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.			
55550	Laparoscopy, surgical, with ligation of spermatic veins for vericocele	71.00	45	3.0+T
55559	Unlisted laparoscopy procedure, spermatic cord	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	SEMINAL VESICLES			
	INCISION			
55600	Vesiculotomy;	120.00	90	3.0+T
55605	complicated	210.00	90	3.0+T
	EXCISION			
55650	Vesiculectomy, any approach	320.00	90	3.0+T
55680	Excision of Mullerian duct cyst	320.00	90	3.0+T
	(For injection procedure, see 52010, 55300)			
	PROSTATE			
	INCISION			
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	20.00	15	3.0+T
55705	incisional, any approach	120.00	30	4.0+T
55720	Prostatotomy, external drainage of prostatic abscess, any approach; simple	120.00	60	4.0+T
55725	complicated	210.00	60	4.0+T
	(For transurethral drainage, see 52700)			
	EXCISION			
	(For transurethral removal of prostate, see 52601-52640)			
	(For transurethral desctruction of prostate, see 53850-53852)			
	(For limited pelvic lymphadenectomy for staging (separate procedure), use 38562)			
	(For independent node dissection, see 38770-38780)			
55801	Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)	320.00	90	6.0+T
55810	Prostatectomy, perineal radical;	400.00	90	6.0+T
55812	with lymph node biopsy(s) (limited pelvic lymphadenectomy)	500.00	90	6.0+T
55815	with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	500.00	90	6.0+T
	(If 55815 is carried out on separate days, use 38770 and 55810)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
55821	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, one or two stages	320.00	90	5.0+T
55831	retropubic, subtotal	320.00	90	5.0+T
55840	Prostatectomy, retropubic radical, with or without nerve sparing;	400.00	90	6.0+T
55842	with lymph node biopsy(s) (limited pelvic lymphadenectomy)	400.00	90	6.0+T
55845	with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	500.00	90	6.0+T
	(If 55845 is carried out on separate days, use 38770 and 55840)			
	(For laparoscopic retropubic radical prostatectomy, use 55866)			
55859	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	159.00	90	3.0+T
55860	Exposure of prostate, any approach, for insertion of radioactive substance;	320.00	90	6.0+T
55862	with lymph node biopsy(s) (limited pelvic lymphadenectomy)	320.00	90	6.0+T
55865	with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	400.00	90	6.0+T

LAPAROSCOPY

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

55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing	400.00	90	6.0+T
	(For open procedure, use 55840)			
	(For application of interstitial radioelement, see 77776-77778)			
	(For ultrasonic guidance for interstitial radioelement application, see 76965)			
55873	Cryosurgical ablation of the prostate (includes ultrasounic guidance for intestinal cryosurgical probe placement)	191.00	30	3.0+T
55899	Unlisted procedure, male genital system	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

FEMALE GENITAL SYSTEM

(For pelvic laparotomy, see 49000)

(For excision or destruction of endometriomas open method, see 49200, 49201)

(For paracentesis, see 49080, 49081)

(For secondary closure of abdominal wall evisceration or disruption, see 49900)

(For fulguration or excision of lesions, laparoscopic approach, see 58662)

(For chemotherapy, see 96400-96549)

VULVA, PERINEUM AND INTROITUS

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

Simple: The removal of skin and superficial subcutaneous tissue.

Radical: The removal of skin and deep subcutaneous tissue.

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

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

INCISION

(For incision and drainage of sebaceous cyst, furuncle, or abscess, see 10060, 10061)

(For incision and drainage of Skene's gland abscess or cyst, see 53060)

56405	Incision and drainage of vulva or perineal abscess	25.00	15	3.0+T
56420	Incision and drainage of Bartholin's gland abscess	20.00	15	3.0+T
56440	Marsupialization of Bartholin's gland cyst	60.00	30	3.0+T
56441	Lysis of labial adhesions	40.00	30	3.0+T

DESTRUCTION

56501	Destruction of lesion(s), vulva; simple, (laser surgery, electrosurgery, cryosurgery, chemosurgery)	8.00		3.0+T
56515	extensive, (laser surgery, electrosurgery, cryosurgery, chemosurgery)	80.00		3.0+T

(For destruction of Skene's gland cyst or abscess, see 53270)
(For cautery destruction of urethral caruncle, see 53265)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	EXCISION			
	(For local excision of fulguration of lesion(s) of external genitalia, see 11420-11426, 11620-11626)			
56605	Biopsy of vulva or perineum. (separate procedure); one lesion	16.00	15	3.0+T
56606	each separate additional lesion (List separately in addition to primary procedure)	8.00		
56620	Vulvectomy simple; partial	160.00	60	3.0+T
56625	complete	220.00	60	3.0+T
56630	Vulvectomy, radical, partial;	339.00	60	3.0+T
56631	with unilateral inguinofemoral lymphadenectomy	453.00	90	5.0+T
56632	with bilateral inguinofemoral lymphadenectomy	462.00	90	5.0+T
56633	Vulvectomy, radical, complete;	359.00	90	5.0+T
56634	with unilateral inguinofemoral lymphadenectomy	468.00	90	5.0+T
56637	with bilateral inguinofemoral lymphadenectomy	478.00	90	5.0+T
56640	Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy	477.00	90	5.0+T
	(For lymphadenectomy, see 38760-38780)			
56700	Partial hymenectomy or revision ofM hymenal ring	40.00	30	3.0+T
56720	Hymenotomy, simple incision	24.00		3.0+T
56740	Excision of Bartholin's gland or cyst	80.00	30	3.0+T
	(For excision of Skene's gland, see 53270) (For excision of urethral caruncle, see 53265) (For excision or fulguration of urethral carcinoma, see 53220; for excision or marsupialization of urethral diverticulum, see 53230-53240)			
	REPAIR			
	(For repair of urethra for mucosal prolapse, see 53275)			
56800	Plastic repair of introitus	80.00	30	3.0+T
56805	Clitoroplasty for intersex state	315.00	90	5.0+T
56810	Perineoplasty, repair of perineum, non-obstetrical (separate procedure)	78.00	30	3.0+T
	(For repair of wounds to genitalia, see 12001-12007, 12041-12047, 13131, 13132) (For anal sphincteroplasty, see 46750, 46751) (For episiorrhaphy, episioperineorrhaphy for recent injury of vulva and/or perineum, nonobstetrical, see 57210)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	ENDOSCOPY			
56820	Colposcopy of the vulva;	35.00	30	3.0+T
56821	with biopsy(s)	45.00	30	3.0+T
	(For colposcopic examinations/procedures involving the vagina, see 57420, 57421; cervix, see 57452-57461)			
	VAGINA			
	INCISION			
57000	Colpotomy; with exploration	60.00	30	3.0+T
57010	with drainage of pelvic abscess	60.00	30	3.0+T
57020	Colpocentesis (separate procedure)	16.00		3.0+T
57022	Incision and drainage of vaginal hematoma; obstetrical/post-partum	28.00	30	3.0+T
57023	non-obstetrical (eg, post-trauma, spontaneous bleeding)	28.00	30	3.0+T
	DESTRUCTION			
57061	Destruction of vaginal lesion(s); simple, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	8.00		3.0+T
57065	extensive, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	80.00		3.0+T
	EXCISION			
57100	Biopsy of vaginal mucosa; simple (separate procedure)	12.00	15	3.0+T
57105	extensive, requiring suture (including cysts)	18.00	15	3.0+T
57106	Vaginectomy, partial removal of vaginal wall;	68.00	90	3.0+T
57107	with removal of paravaginal tissue (radical vaginectomy)	247.00	90	3.0+T
57109	with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)	290.00	90	3.0+T
57110	Vaginectomy, complete removal of vaginal wall;	200.00	60	3.0+T
57111	with removal of paravaginal tissue (radical vaginectomy)	290.00	90	3.0+T
57112	with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)	312.00	90	3.0+T
57120	Colpocleisis (Le Fort Type)	140.00	60	3.0+T
57130	Excision of vaginal septum	26.00	30	3.0+T
57135	Excision of vaginal cyst or tumor	29.00	30	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	INTRODUCTION			
57150	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease	4.00		3.0+T
57155	Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy	114.00	90	3.0+T
	(For insertion of radioelement sources or ribbons, see 77761-77763, 77781-77784)			
57160	Fitting and insertion of pessary or other intravaginal support device	12.00		3.0+T
57180	Introduction of any hemostatic agent or pack for spontaneous or traumatic non-obstetrical hemorrhage (separate procedure)	12.00		3.0+T
	REPAIR			
	(For urethral suspension, Marshall-Marchetti- Krantz type, abdominal approach, see 51840, 51841)			
	(For laparoscopic suspension, use 51990)			
57200	Colporrhaphy, suture of injury of vagina (nonobstetrical)	120.00	60	3.0+T
57210	Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical)	120.00	60	3.0+T
57220	Plastic operation on urethral sphincter, vaginal approach (eg, Kelly urethral plication)	120.00	60	3.0+T
57230	Plastic repair of urethrocele	120.00	60	3.0+T
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	140.00	60	3.0+T
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy (For repair of rectocele (separate procedure) without posterior colporrhapy, see 45560)	140.00	60	3.0+T
57260	Combined anteroposterior colporrhaphy;	200.00		3.0+T
57265	with enterocele repair	290.00	60	4.0+T
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)	81.00		3.0+T
57268	Repair of enterocele, vaginal approach (separate procedure)	180.00	60	4.0+T
57270	Repair of enterocele, abdominal approach (separate procedure)	180.00	60	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
57280	Colpopexy, abdominal approach	180.00	60	4.0+T
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)	240.00	45	4.0+T
57283	intra-peritoneal approach (uterosacral, levator myorrhaphy)	191.00	90	4.0+T
57284	Paravaginal defect repair (including repair of cystocele, stress urinary incontinence, and/or incomplete vaginal prolapse)	231.00	90	4.0+T
57287	Removal or revision of sling for stress incontinence (eg, fascia or synthetic)	115.00	45	3.0+T
57288	Sling operation for stress incontinence (eg, fascia or synthetic) (For laparoscopic approach, use 51992)	240.00	45	4.0+T
57289	Pereyra procedure, including anterior colporrhaphy	210.00	60	3.0+T
57291	Construction of artificial vagina; without graft	240.00	60	3.0+T
57292	with graft	260.00	60	3.0+T
57295	Revision (including removal) of prosthetic vaginal graft, vaginal approach	223.00	90	3.0+T
57300	Closure of rectovaginal fistula; vaginal or transanal approach	240.00	90	5.0+T
57305	abdominal approach	240.00	90	5.0+T
57307	abdominal approach, with concomitant colostomy	280.00	90	5.0+T
57308	transperineal approach, with perineal body reconstruction, with or without levator plication	107.00	90	3.0+T
57310	Closure of urethrovaginal fistula;	200.00	60	4.0+T
57311	with bulbocavernosus transplant	BR	60	3.0+T
57320	Closure of vesicovaginal fistula; vaginal approach	240.00	90	5.0+T
57330	transvesical and vaginal approach	240.00	90	5.0+T
57335	Vaginoplasty for intersex state	380.00	90	3.0+T

(For closure of vesicovaginal fistula, abdominal approach, see 51900)
(For concomitant cystostomy, see 51005-51040)

MANPULATION

57400	Dilation of vagina under anesthesia	8.00		3.0+T
57410	Pelvic examination under anesthesia	8.00		3.0+T
57415	Removal of impacted vaginal foreign body (separate procedure) under anesthesia	14.00	10	3.0+T

(For removal without anesthesia of an impacted vaginal foreign body, use the appropriate Evaluation and Management code)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	ENDOSCOPY			
57420	Colposcopy of the entire vagina, with cervix if present;	36.00		3.0+T
57421	with biopsy(s) of vagina/cervix	40.00		3.0+T
	(For colposcopic visualization of cervix and adjacent upper vagina; use 57452) (For colposcopic examinations/procedures involving the vulva, see 56820, 56821; cervix, see 57452-57461)			
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	260.00	90	3.0+T
	CERVIX UTERI			
	ENDOSCOPY			
	(For colposcopic examinations/procedures involving the vulva, see 56820, 56821, vagina, see 57420, 57421)			
57452	Colposcopy of the cervix including upper/adjacent vagina; (Do not report 57452 in addition to 57454-57461)	44.00		3.0+T
57454	with biopsy(s) of the cervix and endocervical curettage	73.00		3.0+T
57455	with biopsy(s) of the cervix	44.00		3.0+T
57456	with endocervical curettage	41.00		3.0+T
57460	with loop electrode biopsy(s) of the cervix	59.00		3.0+T
57461	with loop electrode conization of the cervix (Do not report 57456 in addition to 57461)	97.00		3.0+T
	EXCISION			
	(For radical surgical procedures, see 58200-58240)			
57500	Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	12.00	15	3.0+T
57505	Endocervical curettage (not done as part of a dilation and curettage)	60.00	15	3.0+T
57510	Cautery of cervix; electro or thermal	41.00		3.0+T
57511	cryocautery, initial or repeat	76.00		3.0+T
57513	laser ablation	149.00		3.0+T
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	204.00	45	3.0+T
57522	loop electrode excision	204.00	45	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
57530	Trachelectomy (cervicectomy), amputation of cervix (separate procedure)	80.00	45	3.0+T
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)	301.00	45	3.0+T
57540	Excision of cervical stump, abdominal approach;	200.00	45	4.0+T
57545	with pelvic floor repair	200.00	45	4.0+T
57550	Excision of cervical stump, vaginal approach;	240.00	45	3.0+T
57555	with anterior and/or posterior repair	240.00	45	3.0+T
57556	with repair of enterocele	330.00	45	3.0+T
	(For insertion of intrauterine device, see 58300)			
REPAIR				
57700	Cerclage of uterine cervix, nonobstetrical	102.00	45	3.0+T
57720	Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach	215.00	60	3.0+T
MANIPULATION				
57800	Dilation of cervical canal, instrumental (separate procedure)	12.00		3.0+T
57820	Dilation and curettage of cervical stump	60.00	15	3.0+T
CORPUS UTERI				
EXCISION				
58100	Endometrial sampling (biopsy), with or without endocervical sampling(biopsy), without cervical dilation, any method (separate procedure)	40.00	15	3.0+T
	(For endocervical currettage only, see 57505)			
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to primary procedure)	5.00		
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	152.00	15	3.0+T
	(For postpartum hemorrhage, see 59160)			
58140	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 grams or less and/or removal of surface myomas; abdominal approach	200.00	45	4.0+T
58145	vaginal approach	200.00	45	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
58146	Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach (Do not report 58146 in addition to 58140-58145, 58150-58240)	200.00	45	4.0+T
	(For codes 58150-58285, see Rule 14)			
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	240.00	45	4.0+T
58152	with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)	320.00	45	4.0+T
	(For urethrocystopexy without hysterectomy, see 51840, 51841)			
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	220.00	45	4.0+T
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)	400.00	90	6.0+T
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s) (For radical hysterectomy with ovarian transposition, use also 58825)	502.00	90	6.0+T
58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof (For pelvic ententeration for lower urinary tract or male genital malignancy, use 51597)	800.00	90	15.0+T
58260	Vaginal hysterectomy, for uterus 250 grams or less;	240.00	45	4.0+T
58262	with removal of tube(s), and/or ovary(s)	270.00	45	4.0+T
58263	with removal of tube(s), and/or ovary(s), with repair of enterocele	295.00	45	4.0+T
58267	with colpo-urethrocystopexy (Marshall-Marchetti-Krantz Type, Pereyra type, with or without endoscopic control)	280.00	45	4.0+T
58270	with repair of enterocele	300.00	45	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
58275	Vaginal hysterectomy, with total or partial vaginectomy;	280.00	45	4.0+T
58280	with repair of enterocele	300.00	45	4.0+T
58285	Vaginal hysterectomy, radical (Schauta type operation)	400.00	90	6.0+T
58290	Vaginal hysterectomy, for uterus greater than 250 grams;	240.00	45	4.0+T
58291	with removal of tube(s) and/or ovary(s)	270.00	45	4.0+T
58292	with removal of tube(s) and/or ovary(s), with repair of enterocele	295.00	45	4.0+T
58293	with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	280.00	45	4.0+T
58294	with repair of enterocele	300.00	45	4.0+T

INTRODUCTION

(For insertion, removal and supply of implantable contraceptive capsules, see 11975, 11976, 11977)

58300	Insertion of intrauterine device (IUD)	49.00		3.0+T
J7300	Intrauterine copper contraceptive			
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg.			
58301	Removal of intrauterine device (IUD)	36.00		3.0+T
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (sis) or hysterosalpingography	12.00		3.0+T
	(For radiological supervision and interpretation of hysterosonography, use 76831) (For radiological supervision and interpretation of hysterosalpingography, use 74740)			
58346	Insertion of Heyman capsules for clinical brachytherapy	121.00	90	3.0+T
	(For insertion of radioelement sources or ribbons, see 77761-77763, 77781-77784)			
58353	Endometrial ablation, thermal, without hysteroscopic guidance	38.00	10	3.0+T
	(For hysteroscopic procedure, use 58563)			

REPAIR

58400	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)	160.00	45	4.0+T
58410	with presacral sympathectomy	180.00	45	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
58520	Hysterorrhaphy, repair of ruptured uterus (nonobstetrical)	160.00	45	4.0+T
58540	Hysteroplasty, repair of uterine anomaly (Strassman type)	BR	45	4.0+T
	(For closure of vesicouterine fistula, see 51920)			

LAPAROSCOPY/HYSTEROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320. To report a diagnostic hysteroscopy (separate procedure), use 58555.

58545	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas	256.00	45	4.0+T
58546	5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams	322.00	45	4.0+T
58550	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; **(see Rule 14)**	279.00	45	4.0+T
58552	with removal of tube(s) and/or ovary(s)	249.00	45	4.0+T
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;	320.00	45	4.0+T
58554	with removal of tube(s) and/or ovary(s)	317.00	45	4.0+T
58555	Hysteroscopy, diagnostic (separate procedure)	60.00	15	3.0+T
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D&C	72.00	15	3.0+T
58559	with lysis of intrauterine adhesions (any method)	72.00	15	3.0+T
58560	with division or resection of intrauterine septum (any method)	72.00	15	3.0+T
58561	with removal of leiomyomata	72.00	15	3.0+T
58562	with removal of impacted foreign body	72.00	15	3.0+T
58563	with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	72.00	15	3.0+T
58565	with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	320.00	90	
58578	Unlisted laparoscopy procedure, uterus	BR		3.0+T
58579	Unlisted hysteroscopy procedure, uterus	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

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	320.00	45	4.0+T
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure) (For laparoscopic procedures, use 58670, 58671)	246.00	45	4.0+T
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)	120.00	45	4.0+T
58615	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach (For laparoscopic approach, use 58671)	200.00	45	4.0+T

LAPAROSCOPY

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

(For laparoscopic biopsy of the ovary or fallopian tube, use 49321)

58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)	72.00	15	3.0+T
58661	with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	210.00	15	3.0+T
58662	with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	72.00	15	3.0+T
58670	with fulguration of oviducts (with or without transection)	181.00	15	3.0+T
58671	with occlusion of oviducts by device (eg, band, clip, or Falope ring)	201.00	15	3.0+T
58673	with salpingostomy (salpingoneostomy) (Code 58673 is used to report unilateral procedures, for bilateral procedure, use modifier -50)	148.00	15	3.0+T
58679	Unlisted laparoscopy procedure, oviduct, ovary	BR	15	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
EXCISION				
58700	Salpingectomy, complete or partial, unilateral or bilateral(separate procedure)	359.00	45	4.0+T
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	406.00	45	4.0+T
REPAIR				
58740	Lysis of adhesions (salpingolysis, ovariolysis) (For laparascopic approach, see 58660)	417.00	45	4.0+T
	(For excision/destruction of endometriomas, open method, see 49200, 49201) (For fulguration or excision of lesions, laparascopic approach, see 58662)			
58770	Salpingostomy (salpingoneostomy) (For laparoscopic approach, use 58672)	200.00	45	4.0+T
OVARY				
INCISION				
58800	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); vaginal approach	100.00	60	4.0+T
58805	abdominal approach	160.00	60	4.0+T
58820	Drainage of ovarian abscess; vaginal approach, open	80.00	60	4.0+T
58822	abdominal approach	160.00	60	4.0+T
58823	Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic) (For radiological supervision and interpretation, use 75989)	36.00		4.0+T
58825	Transposition, ovary(s)	130.00	60	4.0+T
EXCISION				
58900	Biopsy of ovary, unilateral or bilateral (separate procedure) (For laparoscopic biopsy of the ovary or fallopian tube, use 49321)	180.00	60	4.0+T
58920	Wedge resection or bisection of ovary, unilateral or bilateral	180.00	60	4.0+T
58925	Ovarian cystectomy, unilateral or bilateral	180.00	60	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
58940	Oophorectomy, partial or total, unilateral or bilateral;	180.00	60	4.0+T
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	325.00	60	4.0+T
58950	Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy;	290.00		4.0+T
58951	with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy	391.00	60	4.0+T
58952	with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)	435.00	60	4.0+T
58953	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;	546.00	60	4.0+T
58954	with pelvic lymphadenectomy and limited para-aortic lymphadenectomy	572.00	60	4.0+T
58956	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy	377.00	90	4.0+T
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	265.00	60	4.0+T
58999	Unlisted procedure, female genital system, nonobstetrical	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

MATERNITY CARE AND DELIVERY

The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care. Antepartum care includes usual prenatal services (initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, maternity counseling).

Delivery includes vaginal delivery (with or without episiotomy, with or without forceps or breech delivery) and resuscitation of newborn infant when necessary. Postpartum care includes hospital and office visits following vaginal or cesarean section delivery.

For medical complications of pregnancy (toxemia, cardiac problems, neurological problems or other problems requiring additional or unusual services or requiring hospitalization), see services in MEDICINE section. For surgical complications of pregnancy not listed below, see appropriate procedures in SURGERY.

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 59425-59430.

(For circumcision of newborn, see 54150, 54160)
Reimbursement amounts for the Medicaid Obstetrical and Maternal Services Program (MOMS), are noted in parenthesis after the description of each code. For information on the MOMS Program, see Policy Section.

ANTEPARTUM SERVICES

59000	Amniocentesis; diagnostic (For radiological supervision and interpretation, see 76946)	65.00	7	3.0+T
59001	therapeutic amniotic fluid reduction (includes ultrasound guidance)	65.00	7	3.0+T
59012	Cordocentesis (intrauterine), any method (For radiological supervision and interpretation, see 76941)	25.00	7	3.0+T
59015	Chorionic villus sampling, any method (For radiological supervision and interpretation, use 76945)	40.00	7	3.0+T
59020	Fetal contraction stress test	20.00		3.0+T
59025	Fetal non-stress test (MOMS 70.00)	15.00		3.0+T
59030	Fetal scalp blood sampling	20.00		3.0+T
59050	Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation	15.00		3.0+T

EXCISION

59100	Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)	180.00	90	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	200.00	60	5.0+T
59121	tubal or ovarian, without salpingectomy and/or oophorectomy	200.00	60	5.0+T
59130	abdominal pregnancy	200.00	60	5.0+T
59135	interstitial, uterine pregnancy requiring total hysterectomy	240.00	45	4.0+T
59136	interstitial, uterine pregnancy with partial resection of uterus	240.00	45	4.0+T
59140	cervical, with evacuation	BR	60	5.0+T
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	72.00	15	3.0+T
59151	with salpingectomy and/or oophorectomy	160.00	15	3.0+T
59160	Curettage, postpartum	75.00	45	3.0+T

INTRODUCTION

(For intrauterine fetal transfusion, see 36460)

(For introduction of hypertonic solution and/or prostaglandins to initiate labor, see 59850-59857)

59200	Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)	12.00		3.0+T

REPAIR

(For tracheloplasty, see 57700)

59300	Episiotomy or vaginal repair, by other than attending physician	60.00	45	3.0+T
59320	Cerclage of cervix, during pregnancy; vaginal	80.00	45	3.0+T
59325	abdominal	200.00	45	3.0+T
59350	Hysterorrhaphy of ruptured uterus	160.00	45	4.0+T

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) (MOMS 1,440.00)	1,037.00	45	3.0+T
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)(MOMS 883.00)	630.00		3.0+T
59410	including **(inpatient and outpatient)** postpartum care (MOMS 960.00)	679.00	45	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
59414	Delivery of placenta (separate procedure)	35.00	4	3.0+T
59425	Antepartum care only; 4-6 visits (MOMS 364.00)	209.00		
	Procedure code 59425 includes reimbursement for one initial antepartum encounter (54.00) and five subsequent encounters (31.00).			
	If less than 6 antepartum encounters were provided, adjust the amount charged accordingly.			
59426	7 or more visits (MOMS 541.00)	302.00		
	Procedure code 59426 includes reimbursement for one initial antepartum encounter (54.00) and eight subsequent encounters (31.00).			
	If less than 9 antepartum encounters were provided, adjust the amount charged accordingly). For 6 or less antepartum encounters, see code 59425.			
59430	Postpartum care only **(outpatient)** (separate procedure) (MOMS 59.00)	31.00		

CESAREAN DELIVERY

59510	Routine obstetric care including antepartum care, cesarean delivery, and **(inpatient and outpatient)** postpartum care (total, all-inclusive, "global" care)(MOMS 1,440.00)	1,037.00	45	5.0+T
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)(MOMS 883.00)	685.00		5.0+T
59515	including**(inpatient and outpatient)** postpartum care (MOMS 960.00)	734.00	45	5.0+T
59525	Subtotal or total hysterectomy after cesarean delivery (List in addition to 59510, 59514, 59515, or 59618, 59620, 59622)	240.00	45	4.0+T

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) (MOMS 1,440.00)	1,037.00	45	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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) (MOMS 883.00)	630.00		3.0+T
59614	including **(inpatient and outpatient)** postpartum care (MOMS 960.00)	679.00	45	3.0+T
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)(MOMS 1,440.00)	1,037.00	45	5.0+T
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; (when only **inpatient** postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/Mcode(s) for postpartum care visits) (MOMS 883.00)	685.00		5.0+T
59622	including **(inpatient and outpatient)** postpartum care (MOMS 960.00)	734.00	45	5.0+T

ABORTION

(For medical treatment of spontaneous complete abortion, any trimester, use medical service codes 99201-99233) (Ultrasound service(s) provided in conjunction with procedure codes 59812 through 59857 are reimbursable **ONLY** via echography code 76815. Procedure code 76815 should be billed regardless of the approach used to perform the ultrasound (eg, transvaginal))

59812	Treatment of incomplete abortion, any trimester, completed surgically	171.00	45	3.0+T
59820	Treatment of missed abortion, completed surgically; first trimester	194.00	45	3.0+T
59821	second trimester	220.00	45	3.0+T
59830	Treatment of septic abortion, completed surgically	175.00	45	5.0+T
59840	Induced abortion, by dilation and curettage	230.00	45	3.0+T
59841	Induced abortion, by dilation and evacuation	350.00	45	4.0+T
59850	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), (including hospital admission and visits, delivery of fetus and secundines);	322.00	45	4.0+T
59851	with dilation and curettage and/or evacuation	180.00	45	4.0+T
59852	with hysterotomy (failed intra-amniotic injection)	248.00	45	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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;	230.00	45	4.0+T
59856	with dilation and curettage and/or evacuation	350.00	45	4.0+T
59857	with hysterotomy (failed medical evaluation)	248.00	45	4.0+T

(For insertion of hygroscopic cervical dilator, see 59200)

OTHER PROCEDURES

59870	Uterine evacuation and curettage for hydatidiform mole	75.00	45	3.0+T
59871	Removal of cerclage suture under anesthesia (other than local)	23.00		3.0+T
59898	Unlisted laparoscopy procedure, maternity care and delivery	BR		3.0+T
59899	Unlisted procedure, maternity care and delivery	BR		3.0+T

ENDOCRINE SYSTEM

(For pituitary and pineal surgery, see Nervous System)

THYROID GLAND

INCISION

60000	Incision and drainage of thyroglossal duct cyst, infected	12.00		3.0+T

EXCISION

(For fine needle aspiration, see 10021, 10022)

60001	Aspiration and/or injection, thyroid cyst (If imaging guidance is performed, see 76360, 76942)	12.00	2	3.0+T
60100	Biopsy thyroid, percutaneous core needle (If image guidance is performed, see 76003, 76360, 76393, 76942)	12.00	2	3.0+T
60200	Excision of cyst or adenoma of thyroid, or transection of isthmus	160.00	45	5.0+T
60210	Partial thyroid lobectomy, unilateral; with or without isthmusectomy	200.00	45	5.0+T
60212	with contralateral subtotal lobectomy, including isthmusectomy	280.00	45	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	200.00	45	5.0+T
60225	with contralateral subtotal lobectomy, including isthmusectomy	260.00	45	5.0+T
60240	Thyroidectomy, total or complete	280.00	45	5.0+T
60252	Thyroidectomy, total or subtotal for malignancy; with limited neck dissection	320.00	45	5.0+T
60254	with radical neck dissection	400.00	45	6.0+T
60260	Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid	240.00	45	5.0+T
60270	Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach	360.00	45	5.0+T
60271	cervical approach	240.00	45	5.0+T
60280	Excision of thyroglossal duct cyst or sinus;	180.00	45	4.0+T
60281	recurrent	180.00	45	4.0+T

(For thyroid ultrasonography, see 76536)

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

EXCISION

(For excision of remote/disseminated pheochromocytoma, see 49200-49201)

60500	Parathyroidectomy or exploration of parathyroid(s);	280.00	45	5.0+T
60502	re-exploration	280.00	45	5.0+T
60505	with mediastinal exploration, sternal split or transthoracic approach	360.00	60	12.0+T
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)	79.00	45	5.0+T
60520	Thymectomy, partial or total; transcervical approach (separate procedure)	400.00	60	12.0+T
60521	sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)	363.00	60	12.0+T
60522	sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)	406.00	60	12.0+T
60540	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure);	320.00	90	9.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
60545	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal with excision of adjacent retroperitoneal tumor (For laparoscopic approach, use 56321) (For excision of remote or disseminated pheochromocytoma, see 49200, 49201)	400.00	90	9.0+T
60600	Excision of carotid body tumor; without excision of carotid artery	280.00	60	8.0+T
60605	with excision of carotid artery	400.00	60	8.0+T

LAPAROSCOPY

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

60650	Laparoscopy, surgical; with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal	215.00	60	8.0+T
60659	Unlisted laparoscopiy procedure, endocrine system	BR		8.0+T
60699	Unlisted procedure, endocrine system	BR		3.0+T

NERVOUS SYSTEM

SKULL, MENINGES, AND BRAIN

(For injection procedure for cerebral angiography, see 36100-36218)

(For ventriculography, see 61026, 61120, 61130)

(For pneumoencephalography, see 61055)

INJECTION, DRAINAGE OR ASPIRATION

61000	Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initial	12.00		3.0+T
61001	subsequent taps	12.00		3.0+T
61020	Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection	20.00	7	3.0+T
61026	with injection of medicament or other substance for diagnosis or treatment	34.00	7	3.0+T
61050	Cisternal or lateral cervical (Cl-C2) puncture; without injection (separate procedure)	12.00		3.0+T
61055	with injection of medicament or other substance for diagnosis or treatment (Cl-C2)	30.00	7	3.0+T
61070	Puncture of shunt tubing or reservoir for aspiration or injection procedure (For radiological supervision and interpretation, see 75809)	20.00	7	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	TWIST DRILL, BURR HOLE(S) OR TREPHINE			
	(For intracranial neuroendoscopic ventricular catheter placement, use 62160)			
61105	Twist drill hole for subdural or ventricular puncture;	120.00	30	7.0+T
61107	for implanting ventricular catheter or pressure recording device	160.00	30	7.0+T
61108	for evacuation and/or drainage of subdural hematoma	240.00	30	7.0+T
61120	Burr hole(s) for ventricular puncture (including injection of gas, contrast media, dye or radioactive material);	132.00	30	7.0+T
61140	Burr hole(s) or trephine; with biopsy of brain or intracranial lesion	280.00	90	11.0+T
61150	with drainage of brain abscess or cyst	300.00	90	11.0+T
61151	with subsequent tapping (aspiration) of intracranial abscess or cyst	40.00	7	4.0+T
61154	Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural	360.00	60	9.0+T
61156	Burr hole(s); with aspiration of hematoma or cyst, intracerebral	360.00	60	9.0+T
61210	for implanting ventricular catheter, reservoir, EEG electrode(s) or pressure recording device(separate procedure)	160.00	30	7.0+T
61215	Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to ventricular catheter	125.00	30	7.0+T
	(For refilling and maintenance of an implantable infusion pump for spinal or brain drug therapy, use 95990)			
61250	Burr hole(s) or trephine, supratentorial, exploratory, not followed by other surgery	120.00	60	8.0+T
61253	Burr hole(s) or trephine, infratentorial, unilateral or bilateral	120.00	30	7.0+T
	(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	500.00	90	9.0+T
61305	infratentorial (posterior fossa)	600.00	90	11.0+T
61312	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural	400.00	60	9.0+T
61313	intracerebral	400.00	60	9.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
61314	Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural	400.00	60	9.0+T
61315	intracerebellar	400.00	60	9.0+T
61316	Incision and subcutaneous placement of cranial bone graft (List separately in addition to primary procedure)	26.00		9.0+T
	(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	400.00	60	9.0+T
61321	infratentorial	400.00	60	9.0+T
61322	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy	520.00	60	9.0+T
61323	with lobectomy	538.00	60	9.0+T
	(Do not report 61313 in addition to 61322, 61323) (For subtemporal decompression, use 61340)			
61330	Decompression of orbit only, transcranial approach	400.00	90	9.0+T
61332	Exploration of orbit (transcranial approach); with biopsy	400.00	90	9.0+T
61333	with removal of lesion	496.00	90	9.0+T
61334	with removal of foreign body	346.00	90	9.0+T
61340	Subtemporal cranial decompression (pseudotumor cerebri, slit ventrical syndrome)	400.00	90	9.0+T
	(For decompressive craniotomy or craniectomy for intracranial hypertension, without hematoma evacuation, see 61322, 61323)			
61343	Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft (eg, Arnold-Chiari malformation)	578.00	90	9.0+T
61345	Other cranial decompression, posterior fossa	400.00	90	9.0+T
61440	Craniotomy for section of tentorium cerebelli (separate procedure)	300.00	90	11.0+T
61450	Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion	400.00	90	9.0+T
61458	Craniectomy, suboccipital; for exploration or decompression of cranial nerves	600.00	90	9.0+T
61460	for section of one or more cranial nerves	500.00	90	9.0+T
61470	for medullary tractotomy	500.00	90	9.0+T
61480	for mesencephalic tractotomy or pedunculotomy	500.00	90	9.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
61490	Craniotomy for lobotomy, including cingulotomy	160.00	90	9.0+T
61500	Craniectomy; with excision of tumor or other bone lesion of skull	500.00	90	9.0+T
61501	for osteomyelitis	500.00	90	8.0+T
61510	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	500.00	90	9.0+T
61512	for excision of meningioma, supratentorial	500.00	90	9.0+T
61514	for excision of brain abscess, supratentorial	500.00	90	9.0+T
61516	for excision or fenestration of cyst, supratentorial	500.00	90	9.0+T
61517	Implantation of brain intracavitary chemotherapy agent (List separately in addition to primary procedure) (Use 61517 only in conjunction with codes 61510 or 61518) (Do not report 61517 for brachytherapy insertion) (For intracavitary insertion of radioelement sources or ribons, see 77781-77784)	22.00		
61518	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningloma, cerebellopontine angle tumor, or midline tumor at base of skull	600.00	90	11.0+T
61519	meningioma	600.00	90	11.0+T
61520	cerebellopontine angle tumor	600.00	90	11.0+T
61521	midline tumor at base of skull	600.00	90	11.0+T
61522	Craniectomy, infratentorial or posterior fossa; for excision of brain abscess	500.00	90	9.0+T
61524	for excision or fenestration of cyst	500.00	90	9.0+T
61526	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;	400.00	90	9.0+T
61530	combined with middle/posterior fossa craniotomy/craniectomy	480.00	90	9.0+T
61531	Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring (For stereotactic implantation of electrodes, see 61760)	410.00	90	9.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
61533	Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring	410.00	90	11.0+T
	(For continuous EEG monitoring, see 95950-95954)			
61534	for excision of epileptogenic focus without electrocorticography during surgery	500.00	90	9.0+T
61535	for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)	250.00	90	11.0+T
61536	for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)	500.00	90	9.0+T
61537	for lobectomy, temporal lobe, without electrocorticography during surgery	500.00	90	11.0+T
61538	for lobectomy, temporal lobe, with electrocorticography during surgery	400.00	90	11.0+T
61539	for lobectomy, other than temporal lobe, partial or total with electrocorticography during surgery	400.00	90	11.0+T
61540	for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery	500.00	90	11.0+T
61541	for transection of corpus callosum	550.00	90	11.0+T
61542	for total hemispherectomy	660.00	90	11.0+T
61543	for partial or subtotal (functional) hemispherectomy	600.00	90	11.0+T
61544	for excision or coagulation of choroid plexus	200.00	90	11.0+T
61545	for excision of craniopharyngioma	870.00	90	11.0+T
61546	Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach	500.00	90	11.0+T
61548	Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic	280.00	90	4.0+T
61550	Craniectomy for craniosynostosis;single cranial suture	300.00	90	9.0+T
61552	multiple cranial sutures	400.00	90	9.0+T
	(For reconstruction for orbital hypertelorism, see 21260-21263)			
61556	Craniotomy for craniosynostosis; frontal or parietal bone flap	470.00	180	7.0+T
61557	bifrontal bone flap	480.00	180	7.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
61558	Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); not requiring bone grafts	520.00	180	7.0+T
61559	recontouring with multiple osteotomies and bone autografts (eg, barrel-stave procedure) (includes obtaining grafts)	700.00	180	7.0+T
61563	Excision, intra- and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); without optic nerve decompression	BR	180	7.0+T
61564	with optic nerve decompression	720.00	180	7.0+T
61566	Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy	590.00	90	11.0+T
61567	for multiple subpial transections, with electrocorticography during surgery	674.00	90	11.0+T
61570	Craniectomy or craniotomy; with excision of foreign body from brain	400.00	60	9.0+T
61571	with treatment of penetrating wound of brain	430.00	60	9.0+T
	(For sequestrectomy for osteomyelitis, use 61501)			
61575	Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion;	800.00	90	9.0+T
61576	requiring splitting of tongue and/or mandible (including tracheostomy)	800.00	90	9.0+T
	(For arthrodesis, use 22548)			

SURGERY OF SKULL BASE

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

The procedures are categorized according to 1) APPROACH PROCEDURE necessary to obtain adequate exposure to the lesion (pathologic entity), 2) DEFINITIVE PROCEDURE(S) necessary to biopsy, excise or otherwise treat the lesion, and 3) RECONSTRUCTION/REPAIR of the defect present following the definitive procedure(s).

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

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

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

The RECONSTRUCTION/REPAIR PROCEDURE(S) is reported separately if extensive dural grafting, cranioplasty, local or regional myocutaneous pedicle flaps, or extensive skin grafts are required.

For primary closure, see the appropriate codes, ie, 15732, 15755.

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

APPROACH PROCEDURES

ANTERIOR CRANIAL FOSSA

61580	Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration	580.00	90	15.0+T
61581	extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy	660.00	90	15.0+T
61582	extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa	630.00	90	15.0+T
61583	intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa	710.00	90	15.0+T
61584	Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); without orbital exenteration	680.00	90	15.0+T
61585	with orbital exenteration	740.00	90	15.0+T
61586	Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft	510.00	90	15.0+T

MIDDLE CRANIAL FOSSA

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	800.00	90	15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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	850.00	90	15.0+T
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	790.00	90	15.0+T
	POSTERIOR CRANIAL FOSSA			
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	570.00	90	15.0+T
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	680.00	90	15.0+T
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	730.00	90	15.0+T
61598	Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus	650.00	90	15.0+T
	DEFINITIVE PROCEDURES			
	BASE OF ANTERIOR CRANIAL FOSSA			
61600	Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; extradural	510.00	90	15.0+T
61601	intradural, including dural repair, with or without graft	560.00	90	15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	BASE OF MIDDLE CRANIAL FOSSA			
61605	Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural	560.00	90	15.0+T
61606	intradural, including dural repair, with or without graft	750.00	90	15.0+T
61607	Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural	750.00	90	15.0+T
61608	intradural, including dural repair, with or without graft	810.00	90	15.0+T
	(Codes 61609-61612 are reported in addition to code(s) for primary procedure(s) 61605-61608) (Report only one transection or ligation of cartoid artery code per operative session)			
61609	Transection or ligation, carotid artery in cavernous sinus; without repair	190.00	90	15.0+T
61610	with repair by anastomosis or graft	570.00	90	15.0+T
61611	Transection or ligation, carotid artery in petrous canal; without repair	140.00	90	15.0+T
61612	with repair by anastomosis or graft	560.00	90	15.0+T
61613	Obliteration of carotid aneurysm, arteriovenous malformation, or carotid-cavernous fistula by dissection within cavernous sinus	790.00	90	15.0+T
	BASE OF POSTERIOR CRANIAL FOSSA			
61615	Resection or excision of neoplastic vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or CI-C3 vertebral bodies; extradural	620.00	90	15.0+T
61616	intradural, including dural repair, with or without graft	830.00	90	15.0+T
	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)	330.00	90	15.0+T
61619	by local or regionalized vascularized pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle)	400.00	90	15.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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	158.00		3.0+T
	(If selective catheterization and angiography of arteries other than artery to be occluded is performed, use appropriate catheterization and radiologic supervision and interpretation codes)			
	(If complete diagnostic angiography of the artery to be occluded is performed immediately prior to temporary occlusion, use appropriate radiologic supervision and interpretation codes only)			
61624	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)	306.00		3.0+T
61626	non-central nervous system, head or neck (extracranial, brachiocephalic branch) (see also 37204) (For radiological supervision and interpretation, see 75894)	249.00		3.0+T
61630	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	BR	90	3.0+T
61635	Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed	BR	90	3.0+T
61640	Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel	BR		3.0+T
61641	each additional vessel in same vascular family (List separately in addition to primary procedure)	BR		
61642	each additional vessel in different vascular family (List separately in addition to primary procedure)	BR		

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

SURGERY FOR ANEURYSM, ARTERIOVENOUS MALFORMATION OR VASCULAR DISEASE

(Includes craniotomy when appropriate for procedure)

61680	Surgery of intracranial arteriovenous malformation; supratentorial, simple	593.00	90	11.0+T
61682	supratentorial, complex	1,164.00	90	11.0+T
61684	infratentorial, simple	761.00	90	11.0+T
61686	infratentorial, complex	1,222.00	90	11.0+T
61690	dural, simple	565.00	90	11.0+T
61692	dural, complex	977.00	90	11.0+T
61697	Surgery of complex intracranial aneurysm, intracranial approach; cartoid circulation	963.00	90	11.0+T
61698	veretrobasilar circulation	922.00	90	11.0+T
	(61697, 61698 involve aneurysms that are larger than 15 mm or with calcification of the aneurysm neck, or with incorporation of normal vessels into the aneurysm neck, or a procedure requiring temporary vessel occulsion, trapping or cardiopulmonary bypass to successfully treat the aneurysm)			
61700	Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation	600.00	90	11.0+T
61702	vertebral-basilar circulation	600.00	90	11.0+T
61703	Surgery of intracranial aneurysm, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type)	350.00	90	11.0+T
	(For cervical approach for direct ligation of carotid artery, see 37600-37606)			
61705	Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery	600.00	90	11.0+T
61708	by intracranial electrothrombosis	350.00	90	11.0+T
	(For ligation or gradual occlusion of internal/common carotid artery, see 37605, 37606)			
61710	by intra-arterial embolization, injection procedure, or balloon catheter	400.00	90	11.0+T
61711	Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/ cortical) arteries	800.00	90	15.0+T
	(For carotid or vertebral thromboendarterectomy, see 35301)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
STEREOTAXIS				
61720	Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus	340.00	90	11.0+T
61735	subcortical structure(s) other than globus pallidus or thalamus	340.00	90	11.0+T
61750	Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion;	360.00	90	11.0+T
61751	with computed tomography and/or magnetic resonance guidance	370.00	90	11.0+T
	(For radiological supervision and interpretation of computerized tomography, see 70450, 70460, or 70470 as appropriate) (For radiological supervision and interpretation of magnetic resonance imaging, see 70551, 70552, or 70553 as appropriate)			
61760	Stereotactic implantation of depth electrodes into the cerebrum for long term seizure monitoring	423.00	90	11.0+T
61770	Stereotactic localization, including burr hole(s); with insertion of catheter(s) or probe(s) for placement of radiation source	430.00	90	11.0+T
61790	Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); gasserian ganglion	340.00	90	5.0+T
61791	trigeminal medullary tract	BR	90	11.0+T
61793	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions	370.00	90	11.0+T
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.			
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	270.00	90	5.0+T
61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral; cortical	300.00	90	5.0+T
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	300.00	90	5.0+T
61864	each additional array (List separately in addition to primary procedure)	85.00		

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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	300.00	90	5.0+T
61868	each additional array (List separately in addition to primary procedure)	141.00		
61870	Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical	300.00	90	5.0+T
61875	subcortical	300.00	90	5.0+T
61880	Revision or removal of intracranial neurostimulator electrodes	135.00	90	5.0+T
61885	Incision or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	120.00	90	5.0+T
61886	with connection to two or more electrode arrays	150.00	90	5.0+T
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	110.00	90	5.0+T
	(For open placement of cranial nerve (eg, vagal, trigeminal, neurostimulator electrode(s), use 64573) (For percutaneous placement of cranial nerve (eg, vagal, trigeminal) neurostimulator electrode(s), use 64553) (For revision or removal of cranial nerve (eg, vagal, trigeminal) neurostimulator electrode(s), use 64585)			
REPAIR				
62000	Elevation of depressed skull fracture; simple, extradural	300.00	60	9.0+T
62005	compound or comminuted, extradural	340.00	60	9.0+T
62010	with repair of dura and/or debridement of brain	400.00	60	9.0+T
62100	Craniotomy for repair of dural/cerebrospinal fluid leak, including surgery for rhinorrhea/otorrhea	400.00	60	9.0+T
	(For repair of spinal dural/CSF leak, see 63707 or 63709)			
62115	Reduction of craniomegalic skull (eg, treated hydrocephalus); not requiring bone grafts or cranioplasty	540.00	180	7.0+T
62116	with simple cranioplasty	580.00	180	7.0+T
62117	requiring craniotomy and reconstruction with or without bone graft (includes obtaining grafts)	600.00	180	7.0+T
62120	Repair of encephalocele, skull vault, including cranioplasty	560.00	90	9.0+T
62121	Craniotomy for repair of encephalocele, skull base	540.00	180	7.0+T
62140	Cranioplasty for skull defect; up to 5 cm diameter	400.00	60	9.0+T
62141	larger than 5 cm diameter	470.00	60	9.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
62142	Removal of bone flap or prosthetic plate of skull	290.00	60	9.0+T
62143	Replacement of bone flap or prosthetic plate of skull	330.00	60	9.0+T
62145	Cranioplasty for skull defect with reparative brain surgery	400.00	60	9.0+T
62146	Cranioplasty with autograft (includes obtaining bone grafts); up to 5 cm diameter	400.00	180	7.0+T
62147	larger than 5 cm diameter	500.00	180	7.0+T
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)	35.00		

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)	50.00		
62161	Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter)	359.00	90	7.0+T
62162	Neuroendoscopy, intracranial; with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage	461.00	90	7.0+T
62163	with retrieval of foreign body	292.00	90	7.0+T
62164	with excision of brain tumor, including placement of external ventricular catheter for drainage	499.00	90	7.0+T
62165	with excision of pituitary tumor, transnasal or transphenoidal approach	390.00	90	7.0+T

CEREBROSPINAL FLUID (CSF) SHUNT

(For intracranial neuroendoscopic procedures, see 62160-62165)

62180	Ventriculocisternostomy (Torkildsen type operation)	400.00	90	11.0+T
62190	Creation of shunt; subarachnoid/subdural-atrial, -jugular, -auricular	400.00	90	11.0+T
62192	subarachnoid/subdural-peritoneal, -pleural, -other terminus	400.00	90	11.0+T
62194	Replacement or irrigation, subarachnoid/subdural catheter	120.00	30	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
62200	Ventriculocisternostomy, third ventricle	400.00	90	11.0+T
62201	stereotactic, neuroendoscopic method	400.00	90	11.0+T
62220	Creation of shunt; ventriculo-atrial, -jugular, -auricular	400.00	90	11.0+T
62223	ventriculo-peritoneal, -pleural, -other terminus	400.00	90	11.0+T
62225	Replacement or irrigation, ventricular catheter	120.00	30	5.0+T
62230	Replacement or revision of cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system	360.00	90	11.0+T
62252	Reprogramming of programmable cerebrospinal fluid shunt	8.00		
62256	Removal of complete cerebrospinal fluid shunt system; without replacement	120.00	30	11.0+T
62258	with replacement by similar or other shunt at same operation	420.00	90	11.0+T

(For percutaneous irrigation/aspiration of shunt reservoir, see 61070)
(For reprogramming of programmable CSF shunt, use 62252)

SPINE AND SPINAL CORD

INJECTION, DRAINAGE, OR ASPIRATION

Injection of contrast during fluoroscopic guidance and localization is an inclusive component of codes 62263, 62270-62273, 62280-62282, 62310-62319. Fluoroscopic guidance and localization is reported by code 76005, unless a formal contrast study (myelography, epidurography, or arthrography) is performed, in which case the use of fluoroscopy is included in the supervision and interpretation codes.

For radiologic supervision and interpretation of epidurography, use 72275. Code 72275 is only to be used when a epidurogram is performed, recorded, and a formal radiologic report is issued.

Code 62263 describes a catheter-based treatment involving targeted injection of various substances (eg, hypertonic saline, steroid, anesthetic) via an indwelling epidural catheter. Code 62263 includes percutaneous insertion and removal of an epidural catheter (remaining in place over a several-day period), for the administration of multiple injections of a neurolytic agent(s) performed during serial treatment sessions (ie, spanning two or more treatment days). If required, adhesions or scarring may also be lysed by mechanical means. Code 62263 is NOT reported for each adhesiolysis treatment, but should be reported ONCE to describe the entire series of injections/infusions spanning two or more treatment days.

Code 62264 describes multiple adhesiolysis treatment sessions performed on the same day. Adhesions or scarring may be lysed by injections of neurolytic agent(s). If required, adhesions or scarring may also be lysed mechanically using a percutaneously-depolyed catheter.

Codes 62263 and 62264 include the procedure of injections of contrast for epidurography (72275) and fluoroscopic guidance and localization (76005) during initial or subsequent sessions.

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	(For daily hospital management of continuous epidural or subarachnoid drug administration performed in conjunction with codes 62318-62319, see Evaluation and Management Services.)			
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	216.00	7	3.0+T
62264	1 day (Do not report with code 62263)	173.00	7	3.0+T
	(62263 and 62264 include codes 76005 and 72275)			
62268	Percutaneous aspiration, spinal cord cyst or syrinx (For radiological supervision and interpretation, see 76003, 76365,76942)	50.00	7	3.0+T
62269	Biopsy of spinal cord, percutaneous needle (For radiological supervision and interpretation, see 76003, 76360, 76942)	80.00	7	3.0+T
	(For fine needle aspiration, see 10021, 10022)			
62270	Spinal puncture, lumbar, diagnostic	18.00		3.0+T
62272	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)	10.00		3.0+T
62273	Injection, epidural, of blood or clot patch	20.00	7	3.0+T
62280	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions)with or without other therapeutic substance; subarachnoid	30.00		3.0+T
62281	epidural, cervical or thoracic	30.00		3.0+T
62282	epidural, lumbar, sacral (caudal)	30.00		3.0+T
62284	Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)	40.00	7	3.0+T
	(For injection procedure at C1-C2, see 61055)			
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk,any method, single or multiple levels,lumbar (eg, manual or automated percutaneous laser diskectomy)	150.00	7	3.0+T
	(For fluoroscopic guidance, use 76003)			
62290	Injection procedure for diskography, each level; lumbar	40.00	7	3.0+T
62291	cervical or thoracic (For radiological supervision and interpretation, see 72285, 72295)	40.00	7	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
62292	Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar	90.00		3.0+T
62294	Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal	120.00	7	3.0+T
62310	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steriod, other solution), epidural or subarachnoid; cervical or thoracic	20.00	7	3.0+T
62311	lumbar, sacral (caudal)	20.00	7	3.0+T
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) including anesthetic, antispasmodic, opioid, steriod, other solution) epidural or subarachnoid; cervical or thoracic	20.00	7	3.0+T
62319	lumbar, sacral (caudal)	20.00	7	3.0+T

(For transforaminal epidural injection, see 64479-64484)
(For daily hospital management of continuous epidural or subarachnoid drug administration performed in conjunction with codes 62318-62319, see Evaluation and Management services)

CATHETER IMPLANTATION

(For percutaneous placement of intrathecal or epidural catheter, see codes 62270-62273, 62280-62284, 62310-62319)

62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir infusion pump; without laminectomy	116.00	90	3.0+T
62351	with laminectomy	171.00	90	3.0+T

(For refiling and manitenance of an implantable reservoir or infusion pump, for spinal or brain drug therapy, use 95990)

62355	Removal of previously implanted intrathecal or epidural catheter	96.00	90	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	RESEVOIR/PUMP IMPLANTATION			
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir	37.00	90	3.0+T
62361	non-programmable pump	89.00	90	3.0+T
62362	programmable pump, including preparation of pump, with or without programming	116.00	90	3.0+T
62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	96.00	90	3.0+T
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	25.00	90	
62368	with reprogramming	25.00	90	
	(For refilling and maintenance of an implantable infusion pump for spinal or brain drug therapy not involving reprogramming, use 95990)			
	POSTERIOR EXTRADURAL LAMINOTOMY OR LAMINECTOMY FOR EXPLORATION/ DECOMPRESSION OF NEURAL ELEMENTS OR EXCISION OF HERNIATED INTERVERTEBRAL DISKS			
	(When 63001-63048 are followed by arthrodesis, see 22590-22614)			
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), one or two vertebral segments; cervical	400.00	90	7.0+T
63003	thoracic	400.00	90	7.0+T
63005	lumbar, except for spondylolisthesis	400.00	90	7.0+T
63011	sacral	400.00	90	7.0+T
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)	400.00	90	7.0+T
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg. spinal stenosis), more than 2 vertebral segments; cervical	400.00	90	7.0+T
63016	thoracic	400.00	90	7.0+T
63017	lumbar	400.00	90	7.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, cervical	360.00	90	8.0+T
63030	one interspace, lumbar (including open or endoscopically-assisted approach)	360.00	90	7.0+T
63035	each additional interspace, cervical or lumbar (List separately in addition to primary procedure) (Use 63035 in conjunction with codes 63020-63030)	70.00		
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, re-exploration, single interspace; cervical	360.00	90	8.0+T
63042	lumbar	360.00	90	7.0+T
	(Codes 63040 - 63044 are unilateral procedures, for bilateral procedures, use modifier -50)			
63043	each additional cervical interspace (List separately in addition to primary procedure) (Use 63043 in conjunction with code 63040)	70.00		
63044	each additional lumbar interspace (List separately in addition to primary procedure) (Use 63044 in conjunction with code 63042)	70.00		
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	400.00	90	8.0+T
63046	thoracic	400.00	90	7.0+T
63047	lumbar	400.00	90	7.0+T
63048	each additional segment, cervical thoracic or lumbar (List separately in addition to primary procedure) (Use 63048 in conjunction with codes 63045-63047)	70.00		
63050	Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments;	400.00	90	8.0+T
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)	455.00	90	8.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	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	460.00	90	7.0+T
63056	lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disk)	460.00	90	7.0+T
63057	each additional segment, thoracic or lumbar (List separately in addition to primary procedure) (Use 63057 in conjunction with codes 63055, 63056)	100.00	90	
63064	Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic; single segment	360.00	90	7.0+T
63066	each additional segment (List separately in addition to primary procedure) (Use 63066 in conjunction with code 63064)	65.00	90	
	(For excision of thoracic intraspinal lesions by laminectomy, see 63266, 63271, 63276, 63281 and 63286)			
	ANTERIOR OR ANTEROLATERAL APPROACH FOR EXTRADURAL EXPLORATION/DECOMPRESSION			
63075	Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	320.00	90	7.0+T
63076	cervical, each additional interspace (Use in conjunction with code 63075)	80.00		
63077	thoracic, single interspace	320.00	90	7.0+T
63078	thoracic, each additional interspace (Use in conjunction with code 63077)	80.00		
	(Do not report code 69990 in addition to codes 63075-63078)			
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment	500.00	90	8.0+T
63082	cervical, each additional segment (Use 63082 in conjunction with code 63081)	90.00	90	
	(For transoral approach, see 61575-61576)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
63085	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment	550.00	90	7.0+T
63086	thoracic, each additional segment (Use 63086 in conjunction with code 63085)	65.00	90	
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	690.00	90	7.0+T
63088	each additional segment (Use 63088 in conjunction with code 63087)	90.00	90	
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	560.00	90	7.0+T
63091	each additional segment (Use 63091 in conjunction with code 63090)	60.00	90	

(Procedures 63081-63091 include diskectomy above and/or below vertebral segment)
(If followed by arthrodesis, see 22548-22812)
(For reconstruction of spine, use appropriate vertebral corpectomy codes 63081-63091, bone graft codes 20930-20938, arthrodesis codes 22548-22812, and spinal instrumentation codes 22840-22855)

LATERAL EXTRACAVITARY APPROACH FOR EXTRADURAL EXPLORATION/DECOMPRESSION

63101	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment	400.00	90	7.0+T
63102	lumbar, single segment	400.00	90	7.0+T
63103	thoracic or lumbar, each additional segment (List separately in addition to primary procedure)	80.00		

INCISION

63170	Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic or thoracolumbar	600.00	90	7.0+T
63172	Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid space	600.00	90	7.0+T
63173	to peritoneal or plueral space	500.00	90	7.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
63180	Laminectomy and section of dentate ligaments, with or without dural graft, cervical; one or two segments	600.00	90	7.0+T
63182	more than two segments	240.00	90	7.0+T
63185	Laminectomy with rhizotomy; one or two segments	300.00	60	8.0+T
63190	more than two segments	300.00	60	8.0+T
63191	Laminectomy with section of spinal accessory nerve	400.00	90	7.0+T
	(For resection of sternocleidomastoid muscle, use 21720)			
63194	Laminectomy with cordotomy, with section of one spinothalamic tract, one stage; cervical	400.00	90	8.0+T
63195	thoracic	400.00	90	8.0+T
63196	Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage; cervical	600.00	90	8.0+T
63197	thoracic	600.00	90	8.0+T
63198	Laminectomy with cordotomy, with section of both spinothalamic tracts, two stages within 14 days; cervical	BR	90	8.0+T
63199	thoracic	BR	90	8.0+T
63200	Laminectomy, with release of tethered spinal cord, lumbar	400.00	90	7.0+T
	EXCISION BY LAMINECTONY OF LESION OTHER THAN HERNIATED DISK			
63250	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical	400.00	90	7.0+T
63251	thoracic	400.00	90	7.0+T
63252	thoracolumbar	400.00	90	7.0+T
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical	400.00	90	7.0+T
63266	thoracic	400.00	90	7.0+T
63267	lumbar	400.00	90	7.0+T
63268	sacral	400.00	90	7.0+T
63270	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical	400.00	90	7.0+T
63271	thoracic	400.00	90	7.0+T
63272	lumbar	400.00	90	7.0+T
63273	sacral	400.00	90	7.0+T
63275	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical	400.00	90	7.0+T
63276	extradural, thoracic	400.00	90	7.0+T
63277	extradural, lumbar	400.00	90	7.0+T
63278	extradural, sacral	400.00	90	7.0+T
63280	intradural, extramedullary, cervical	400.00	90	7.0+T
63281	intradural, extramedullary, thoracic	400.00	90	7.0+T
63282	intradural, extramedullary, lumbar	400.00	90	7.0+T
63283	intradural, sacral	400.00	90	7.0+T
63285	intradural, intramedullary, cervical	400.00	90	7.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
63286	Laminectomy for biopsy/excision of intraspinal neoplasm;intradural, intramedullary, thoracic	400.00	90	7.0+T
63287	intradural, intramedullary, thoracolumbar	400.00	90	7.0+T
63290	combined extradural-intradural lesion, any level	725.00	90	7.0+T
63295	Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to primary procedure)	91.00		7.0+T

(For drainage of intramedullary cyst/syrinx, use 63172, 63173)

EXCISION, ANTERIOR OR ANTEROLATERAL APPROACH, INTRASPINAL LESION

(For arthrodesis, see 22548-22632)

(For reconstruction of spine, see 20930-20938)

63300	Vertebral corpectomy (vertebral body resection), partial or complete for excision of intraspinal lesion, single segment; extradural, cervical	475.00	90	7.0+T
63301	extradural, thoracic by transthoracic approach	550.00	90	7.0+T
63302	extradural, thoracic by thoracolumbar approach	535.00	90	7.0+T
63303	extradural, lumbar or sacral by transperitoneal or retroperitoneal approach	600.00	90	7.0+T
63304	intradural, cervical	560.00	90	7.0+T
63305	intradural, thoracic by transthoracic approach	610.00	90	7.0+T
63306	intradural, thoracic by thoracolumbar approach	560.00	90	7.0+T
63307	intradural, lumbar or sacral by transperitoneal or retroperitoneal approach	650.00	90	7.0+T
63308	each additional segment (List separately in addition to codes for single segment) (Use in conjunction with codes 63300-63307)	100.00	90	

STEREOTAXIS

63600	Creation of lesion of spinal cord by stereotactic method, percutaneous, any modality (including stimulation and/or recording)	BR	12	8.0+T
63610	Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery	BR	12	8.0+T
63615	Stereotactic biopsy, aspiration, or excision of lesion spinal cord	BR	12	8.0+T

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.

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

Codes 63650, 63655, and 63660 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, 63660), 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, 63660), the contacts are on a plate or paddle-shaped surface.

63650	Percutaneous implantation of neurostimulator electrode array, epidural	180.00	90	8.0+T
63655	Laminectomy for implantation of neuro-stimulator electrodes plate/paddle,epidural	360.00	90	8.0+T
63660	Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)	160.00	12	8.0+T
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	200.00	12	8.0+T
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	160.00	12	8.0+T

REPAIR

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

63700	Repair of meningocele; less than 5 cm diameter	300.00	90	9.0+T
63702	larger than 5 cm diameter	300.00	90	9.0+T
63704	Repair of myelomeningocele; less than 5 cm diameter	360.00	90	9.0+T
63706	larger than 5 cm diameter	360.00	90	9.0+T
63707	Repair of dural/cerebrospinal fluid leak, not requiring laminectomy	235.00	90	9.0+T
63709	Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy	300.00	90	9.0+T
63710	Dural graft, spinal	280.00	90	9.0+T

(For complex skin closure, see Integumentary System)
(For laminectomy and section of dentate ligaments, with or without dural graft cervical, see 63180-63182)

SHUNT, SPINAL CSF

63740	Creation of shunt, lumbar, subarachnoid- peritoneal, -pleural, or other; including laminectomy	400.00	90	7.0+T
63741	percutaneous, not requiring laminectomy	275.00	12	8.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
63744	Replacement, irrigation or revision of lumbosubarachnoid shunt	275.00	12	8.0+T
63746	Removal of entire lumbosubarachnoid shunt system without replacement	220.00	12	8.0+T

EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM

(For intracranial surgery on cranial nerves, see 61450, 61460, 61790)

INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC 0R THERAPEUTIC:

SOMATIC NERVES

64400	Injection, anesthetic agent; trigeminal nerve, any division or branch	30.00	30
64402	facial nerve	30.00	30
64405	greater occipital nerve	20.00	7
64408	vagus nerve	20.00	7
64410	phrenic nerve	12.00	7
64412	spinal accessory nerve	20.00	7
64413	cervical plexus	20.00	7
64415	brachial plexus, single	20.00	7
64416	brachial plexus,continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration	20.00	7
64417	axillary nerve	20.00	7
64418	suprascapular nerve	12.00	7
64420	intercostal nerve, single	12.00	7
64421	intercostal nerves, multiple, regional block	12.00	7
64425	ilioinguinal, iliohypogastric nerves	20.00	7
64430	pudendal nerve	20.00	7
64435	paracervical (uterine) nerve	20.00	7
64445	sciatic nerve, single	12.00	7
64446	sciatic nerve, continuous infusion by catheter, (including catheter placement) including daily management for anesthetic agent administration	12.00	7
64447	femoral nerve, single	12.00	7
64448	femoral nerve, continuous infusion by catheter, (including catheter placement) including daily management for anesthetic agent administration	12.00	7
64449	lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration	12.00	10
64450	other peripheral nerve or branch	12.00	7

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	(For subarachnoid or subdural, injection, see 62280, 62310-62319) (For phenol destruction, see 64622-64627) (For epidural or caudal injection, see 62273, 62281-62282, 62310-62319)			
	(Codes 64470-64484 are unilateral procedures, for bilateral procedures use modifier -50) (For fluoroscopic guidance and localization for needle placement and injection in conjunction with codes 64470-64484, use code 76005)			
64470	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level	20.00	7	
64472	cervical or thoracic, each additional level (List separately in addition to primary procedure) (Use code 64472 in conjunction with code 64470)	10.00		
64475	lumbar or sacral, single level	20.00	7	
64476	lumbar or sacral, each additional level (List separately in addition to primary procedure) (Use code 64476 in conjunction with code 64475)	10.00		
64479	Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level	20.00	7	
64480	cervical or thoracic, each additional level (List separately in addition to primary procedure) (Use code 64480 in conjunction with code 64479)	10.00		
64483	Injection, anesthetic agent and/or steriod, transforaminal epidural; lumbar or sacral, single level	20.00	7	
64484	lumbar or sacral, each additional level (List separately in addition to primary procedure) (Use code 64484 in conjunction with code 64483)	10.00		
	SYMPATHETIC NERVES			
64505	Injection, anesthetic agent; sphenopalatine ganglion	20.00	7	
64508	carotid sinus (separate procedure)	20.00	7	
64510	stellate ganglion (cervical sympathetic)	20.00	7	
64517	superior hypogastric plexus	20.00		
64520	lumbar or thoracic (paravertebral sympathetic)	20.00	7	
64530	celiac plexus, with or without radiologic monitoring	20.00	7	

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

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 electrodes;cranial nerve	125.00	45	3.0+T
	(For open placement of cranial nerve (eg, vagal, trigeminal) neurostimulator pulse generator or receiver, see 61885, 61886, as appropriate)			
64555	peripheral nerve (excludes sacral nerve)	60.00	45	3.0+T
64560	autonomic nerve	75.00	45	3.0+T
64561	sacral nerve (transforaminal placement)	80.00	45	3.0+T
64565	neuromuscular	BR		3.0+T
64573	Incision for implantation of neurostimulator electrodes; cranial nerve	200.00	45	3.0+T
64575	peripheral nerve (excludes sacral nerve)	125.00	45	3.0+T
64577	autonomic nerve	125.00	45	3.0+T
64580	neuromuscular	125.00	45	3.0+T
64581	sacral nerve (transforaminal placement)	BR		3.0+T
64585	Revision or removal of peripheral neurostimulator electrodes	60.00	45	3.0+T
64590	Insertion or replacement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling	60.00	45	3.0+T
64595	Revision or removal of peripheral neurostimulator pulse generator or receiver	60.00	45	3.0+T

DESTRUCTION BY NEUROLYTIC AGENT (EG, CHEMICAL, THERMAL, ELECTRICAL, RADIOFREOUENCY OR CHEMODENERVATION)

SOMATIC NERVES

64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch	40.00	15	3.0+T
64605	second and third division branches at foramen ovale	30.00	30	3.0+T
64610	second and third division branches at foramen ovale under radiologic monitoring	40.00	30	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)	40.00	15	3.0+T
64613	neck muscle(s) (eg, for spasmodic torticollis, spasmotic dysphonia)	40.00	15	3.0+T
64614	extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)	40.00	15	3.0+T
	(For chemodenervation for strabismus involving the extraocular muscles, see 67345)			
64620	Destruction by neurolytic agent; intercostal nerve	12.00	7	3.0+T
	(Codes 64622-64677 are unilateral procedures, for bilateral procedures use modifier -50) (For fluoroscopic guidance and localization for needle placement and neurolysis in conjunction with codes 64622-64627, use 76005)			
64622	Destruction by neurolytic agent, paravertebral facet joint nerve;lumbar or sacral, single level	20.00	7	3.0+T
64623	lumbar or sacral, each additional level (List separately in addition to primary procedure) (Use 64623 in conjunction with code 64622)	20.00	7	3.0+T
64626	cervical or thoracic, single level	20.00	7	3.0+T
64627	cervical or thoracic, each additional level (List separately in addition to primary procedure)	10.00		
64630	Destruction by neurolytic agent; pudendal nerve	20.00	7	3.0+T
64640	other peripheral nerve or branch	12.00	7	3.0+T
	SYMPATHETIC NERVES			
64650	Chemodenervation of eccrine glands; both axillae	13.00		3.0+T
64653	other area(s) (eg, scalp, face, neck), per day	15.00		3.0+T
64680	Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus	50.00	7	3.0+T
64681	superior hypogastric plexus	69.00	10	

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	NEUROPLASTY (EXPLORATION, NEUROLYSIS OR NERVE DECOMPRESSION)			
	Neuroplasty is the decompression or freeing of intact nerve from scar tissue, including external neurolysis and/or transposition. (For internal neurolysis requiring use of operating microscope, use 64727) (For facial nerve decompression, see 69720)			
64702	Neuroplasty; digital, one or both, same digit	60.00	90	3.0+T
64704	nerve of hand or foot	80.00	90	3.0+T
64708	Neuroplasty, major peripheral nerve, arm or leg; other than specified	160.00	90	3.0+T
64712	sciatic nerve	180.00	90	3.0+T
64713	brachial plexus	200.00	90	5.0+T
64714	lumbar plexus	200.00	90	5.0+T
64716	Neuroplasty and/or transposition; cranial nerve (specify)	300.00	90	5.0+T
64718	ulnar nerve at elbow	100.00	90	3.0+T
64719	ulnar nerve at wrist	80.00	90	3.0+T
64721	median nerve at carpal tunnel (For arthroscopic procedure, see 29848)	120.00	45	3.0+T
64722	Decompression; unspecified nerve(s) (specify)	140.00	45	3.0+T
64726	plantar digital nerve	60.00	90	3.0+T
	TRANSECTION OR AVULSION			
	(For stereotactic lesion of gasserian ganglion, see 61790) (For section of recurrent laryngeal nerve, see 31595)			
64732	Transection or avulsion of; supraorbital nerve	80.00	60	3.0+T
64734	infraorbital nerve	80.00	60	3.0+T
64736	mental nerve	80.00	60	3.0+T
64738	inferior alveolar nerve by osteotomy	115.00	60	3.0+T
64740	lingual nerve	BR	60	3.0+T
64742	facial nerve, differential or complete	BR	60	3.0+T
64744	greater occipital nerve	160.00	60	4.0+T
64746	phrenic nerve	60.00	30	3.0+T
64752	vagus nerve (vagotomy), transthoracic	175.00	60	4.0+T
64755	vagus nerve limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy) (For laparoscopic approach, use 43652)	300.00	60	4.0+T
64760	vagus nerve (vagotomy), abdominal (For laparoscopic approach, use 43651)	BR		4.0+T
64761	pudendal nerve	BR		4.0+T
64763	Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy	160.00	60	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
64766	Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy	160.00	60	3.0+T
64771	Transection or avulsion of other cranial nerve, extradural	160.00	60	4.0+T
64772	Transection or avulsion of other spinal nerve, extradural	160.00	60	3.0+T

(For excision of tender scar, skin and subcutaneous tissue, with or without tiny neuroma, see 11400-11446, 13100-13153)

EXCISION

SOMATIC NERVES

(For Morton neurectomy, see 28080)

64774	Excision of neuroma; cutaneous nerve, surgically identifiable	32.00	60	3.0+T
64776	digital nerve, one or both, same digit	40.00	60	3.0+T
64778	digital nerve, each additional digit (List separately in addition to primary procedure) (Use 64778 in conjunction with code 64776)	6.00		
64782	hand or foot, except digital nerve	60.00	60	3.0+T
64783	hand or foot, each additional nerve, except same digit (List separately in addition to primary procedure) (Use 64783 in conjunction with code 64782)	6.00		
64784	major peripheral nerve, except sciatic	100.00	60	3.0+T
64786	sciatic nerve	100.00	60	3.0+T
64787	Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision) (Use 64787 in conjunction with codes 64774-64786)	100.00	60	3.0+T
64788	Excision of neurofibroma or neurolemmoma; cutaneous nerve	32.00		3.0+T
64790	major peripheral nerve	100.00		3.0+T
64792	extensive (including malignant type)	160.00		3.0+T
64795	Biopsy of nerve	20.00		3.0+T

SYMPATHETIC NERVES

64802	Sympathectomy, cervical	240.00		6.0+T
64804	Sympathectomy,cervicothoracic	280.00		6.0+T
64809	Sympathectomy, thoracolumbar	260.00		5.0+T
64818	Sympathectomy, lumbar	220.00		4.0+T

(Do not report 69990 in addition to codes 64820, 64821, 64822, 64823)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
64820	Sympathectomy; digital arteries, each digit	183.00	60	3.0+T
64821	radial artery	181.00	60	3.0+T
64822	ulnar artery	181.00	60	3.0+T
64823	superficial palmar arch	209.00	60	3.0+T
NEURORRHAPHY				
64831	Suture of digital nerve, hand or foot; one nerve	60.00	90	3.0+T
64832	each additional digital nerve (List separately in addition to primary procedure) (Use 64832 in conjunction with code 64831)	15.00		
64834	Suture of one nerve, hand or foot; common sensory nerve	80.00	90	3.0+T
64835	median motor thenar	120.00	90	3.0+T
64836	ulnar motor	120.00	90	3.0+T
64837	Suture of each additional nerve, hand or foot (List separately in addition to primary procedure) (Use 64837 in conjunction with codes 64834-64836)	30.00		
64840	Suture of posterior tibial nerve	160.00	90	3.0+T
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition	160.00	90	3.0+T
64857	without transposition	160.00	90	3.0+T
64858	Suture of sciatic nerve	200.00	90	3.0+T
64859	Suture of each additional major peripheral nerve (List separately in addition to primary procedure) (Use 64859 in conjunction with codes 64856, 64857)	50.00		
64861	Suture of; brachial plexus	200.00	90	3.0+T
64862	lumbar plexus	200.00	90	3.0+T
64864	Suture of facial nerve; extracranial	300.00	90	5.0+T
64865	infratemporal, with or without grafting	300.00	90	5.0+T
64866	Anastomosis; facial-spinal accessory	300.00	90	6.0+T
64868	facial-hypoglossal	300.00	90	6.0+T
64870	facial-phrenic	300.00	90	6.0+T
	(Use 64872, 64874, 64876 in conjunction with codes 64831-64865)			
64872	Suture of nerve; requiring secondary or delayed suture (List separately in addition to code for primary neurorrhaphy)	40.00	90	3.0+T
64874	requiring extensive mobilization, or transposition of nerve (List separately in addition to code for nerve suture)	55.00	90	3.0+T
64876	requiring shortening of bone of extremity (List separately in addition to code for nerve suture)	BR		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	NEURORRHAPHY WITH NERVE GRAFT			
64885	Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length	340.00	90	3.0+T
64886	more than 4 cm in length	400.00	90	3.0+T
64890	Nerve graft (includes obtaining graft), single strand hand or foot; up to 4 cm length	310.00	90	3.0+T
64891	more than 4 cm length	275.00	90	3.0+T
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length	275.00	90	3.0+T
64893	more than 4 cm length	320.00	90	3.0+T
64895	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length	350.00	90	3.0+T
64896	more than 4 cm length	360.00	90	3.0+T
64897	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm. length	350.00	90	3.0+T
64898	more than 4 cm length	390.00	90	3.0+T
64901	Nerve graft, each additional nerve; single strand (List separately in addition to primary procedure) (Use 64901 in conjunction with codes 64885-64893)	190.00	90	3.0+T
64902	multiple strands (cable) (List separately in addition to primary procedure) (Use 64902 in conjunction with codes 64885, 64886, 64895-64898)	220.00	90	3.0+T
64905	Nerve pedicle transfer; first stage	260.00	90	3.0+T
64907	second stage	350.00	90	3.0+T
64999	Unlisted procedure, nervous system	BR		3.0+T

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	160.00	30	4.0+T
65093	with implant	200.00	30	4.0+T
65101	Enucleation of eye; without implant	160.00	30	4.0+T
65103	with implant, muscles not attached to implant	160.00	30	4.0+T
65105	with implant, muscles attached to implant	200.00	30	4.0+T

(For conjunctivoplasty after enucleation, see 68320 et seq)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
65110	Exenteration of orbit (does not include skin graft), removal of orbital contents; only	240.00	60	7.0+T
65112	with therapeutic removal of bone	300.00	60	7.0+T
65114	with muscle or myocutaneous flap	300.00	60	7.0+T

(For skin graft to orbit (split skin), see 15120, 15121; free, full thickness, see 15260, 15261),
(For eyelid repair involving more than skin, see 67930 et seq)

SECONDARY IMPLANT(S) PROCEDURES

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

65125	Modification of ocular implant with placement or replacement of pegs (eg, drilling receptacle for prosthesis appendage) (separate procedure)	BR		4.0+T
65130	Insertion of ocular implant secondary; after evisceration, in scleral shell	240.00	30	4.0+T
65135	after enucleation, muscles not attached to implant	240.00	30	4.0+T
65140	after enucleation, muscles attached to implant	240.00	30	4.0+T
65150	Reinsertion of ocular implant; with or without conjunctival graft	240.00	30	4.0+T
65155	with use of foreign material for reinforcement and/or attachment of muscles to implant	240.00	30	4.0+T
65175	Removal of ocular implant	200.00	30	4.0+T

(For orbital implant insertion, see 67550; removal, see 67560)

REMOVAL OF FOREIGN BODY

(For removal of implanted material: ocular implant, see 65175; anterior segment implant, see 65920; posterior segment implant, see 67120; orbital implant, see 67560)

(For removal of foreign body: orbit, see 61334, 67413, 67430; eyelid, see 67938; lacrimal system, see 68530)

(For diagnostic X-ray for foreign body, see 70030; for diagnostic echography for foreign body, see 76529)

65205	Removal of foreign body, external eye; conjunctival superficial	4.00		3.0+T
65210	conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating	8.00		3.0+T
65220	corneal, without slit lamp	8.00		3.0+T
65222	corneal, with slit lamp	12.00		3.0+T

(For repair of corneal laceration with foreign body, see 65275)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
65235	Removal of foreign body, intraocular; from anterior chamber of eye or lens	200.00	45	6.0+T
65260	from posterior segment, magnetic extraction, anterior or posterior route	200.00	45	6.0+T
65265	from posterior segment, nonmagnetic extraction	200.00	45	6.0+T

REPAIR OF LACERATION

Repair of laceration includes use of conjunctival flap and restoration of anterior chamber, by air or saline injection when indicated.

(For fracture of orbit, see 21385 et seq)
(For repair of wound of eyelid, see 12011-12018, 12051-12057, linear, complex, see 13150-13160, other, 67930-67935; of lacrimal system, see 68700; of iris or ciliary body, see 66680)\
(For repair of operative wound, see 66250)

65270	Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure	20.00	15	4.0+T
65272	conjunctiva, by mobilization and rearrangement, without hospitalization	20.00	15	4.0+T
65273	conjunctiva, by mobilization and rearrangement, with hospitalization	20.00	15	4.0+T
65275	cornea, nonperforating, with or without removal foreign body	120.00	45	6.0+T
65280	cornea and/or sclera, perforating, not involving uveal tissue	165.00	45	6.0+T
65285	cornea and/or sclera, perforating,with reposition or resection of uveal tissue	280.00	45	8.0+T
65286	application of tissue glue, wounds of cornea and/or sclera	120.00	45	6.0+T
65290	Repair of wound, extraocular muscle, tendon and/or Tenon's capsule	130.00	45	8.0+T

ANTERIOR SEGMENT

CORNEA

EXCISION

65400	Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium	140.00	30	6.0+T
65410	Biopsy of cornea	40.00	30	3.0+T
65420	Excision or transposition of pterygium; without graft	100.00	30	4.0+T
65426	with graft	100.00	30	4.0+T

REMOVAL OR DESTRUCTION

65430	Scraping of cornea, diagnostic, for smear and/or culture	10.00		3.0+T
65435	Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)	20.00		3.0+T
65436	with application of chelating agent, eg, EDTA	20.00		3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
65450	Destruction of lesion of cornea by cryotherapy, photocoagulation or thermocauterization	20.00		3.0+T
65600	Multiple punctures of anterior cornea (eg, for corneal erosion, tattoo)	120.00	30	4.0+T
	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); lamellar	400.00	90	8.0+T
65730	penetrating (except in aphakia)	440.00	90	8.0+T
65750	penetrating (in aphakia)	440.00	90	8.0+T
65755	penetrating (in pseudophakia)	440.00	90	8.0+T
	OTHER PROCEDURES			
65760	Keratomileusis	400.00	90	8.0+T
65765	Keratophakia	400.00	90	8.0+T
65767	Epikeratoplasty	BR	90	8.0+T
65770	Keratoprosthesis	480.00	90	8.0+T
65771	Radial keratotomy	240.00	90	8.0+T
65772	Corneal relaxing incision for correction of surgically induced astigmatism	200.00	90	8.0+T
65775	Corneal wedge resection for correction of surgically induced astigmatism	BR	90	8.0+T
	ANTERIOR CHAMBER			
	INCISION			
65800	Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous	16.00		3.0+T
65805	with therapeutic release of aqueous	16.00		3.0+T
65810	with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection	60.00	30	4.0+T
65815	with removal of blood, with or without irrigation and/or air injection	100.00	30	4.0+T
	(For injection, see 66020-66030) (For removal of blood clot, see 65930)			
65820	Goniotomy (Do not report modifier -63 in conjunction with 65820)	200.00	30	4.0+T
65850	Trabeculotomy ab externo	300.00	90	6.0+T
65855	Trabeculoplasty by laser surgery, one or more sessions (defined treatment series) (For trabeculectomy, see 66170)	300.00	90	6.0+T
65860	Severing adhesions of anterior segment, laser technique (separate procedure)	200.00	45	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	OTHER PROCEDURES			
65865	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); goniosynechiae	200.00	45	4.0+T
65870	anterior synechiae, except goniosynechiae	200.00	45	4.0+T
65875	posterior synechiae	200.00	45	4.0+T
65880	corneovitreal adhesions	200.00	45	4.0+T
	(For laser surgery, use 66821)			
65900	Removal of epithelial downgrowth, anterior chamber of eye	120.00	30	6.0+T
65920	Removal of implanted material, anterior segment of eye	60.00	15	4.0+T
65930	Removal of blood clot, anterior segment of eye	60.00	15	4.0+T
66020	Injection, anterior chamber of eye (separate procedure); air or liquid	60.00	15	4.0+T
66030	medication	60.00	15	4.0+T
	ANTERIOR SCLERA			
	EXCISION			
	(For removal of intraocular foreign body, see 65235)			
	(For operations on posterior sclera, see 67250-67255)			
66130	Excision of lesion, sclera	200.00	45	6.0+T
66150	Fistulization of sclera for glaucoma; trephination with iridectomy	240.00	45	6.0+T
66155	thermocauterization with iridectomy	240.00	45	6.0+T
66160	sclerectomy with punch or scissors, with iridectomy	240.00	45	6.0+T
66165	iridencleisis or iridotasis	240.00	45	6.0+T
66170	trabeculectomy ab externo in absence of previous surgery	240.00	45	6.0+T
66172	trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	288.00	45	6.0+T
	(For trabeculotomy ab externo, see 65850)			
	(For repair of operative wound, see 66250)			
66180	Aqueous shunt to extraocular reservoir, (eg, Molteno, Schocket, Denver-Krupin)	300.00	90	8.0+T
66185	Revision of aqueous shunt to extraocular reservoir	180.00	90	8.0+T
	(For removal of implanted shunt, use 67120)			
	REPAIR OR REVISION			
	(For scleral procedures in retinal surgery, see 67101 et seq)			
	(For scleral reinforcement, see 67250, 67255)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
66220	Repair of scleral staphyloma; without graft	BR		6.0+T
66225	with graft	BR		6.0+T
66250	Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure	120.00	30	6.0+T
	(For unlisted procedure on anterior sclera, see 66999)			

IRIS, CILIARY BODY

INCISION

66500	Iridotomy by stab incision (separate procedure); except transfixion	80.00	30	4.0+T
66505	with transfixion as for iris bombe	80.00	30	4.0+T
	(For iridotomy by photocoagulation, see 66761)			

EXCISION

66600	Iridectomy, with corneoscleral or corneal section; for removal of lesion	240.00	45	4.0+T
66605	with cyclectomy	320.00	45	4.0+T
66625	peripheral for glaucoma (separate procedure)	200.00	45	4.0+T
66630	sector for glaucoma (separate procedure)	200.00	45	4.0+T
66635	optical (separate procedure)	200.00	45	4.0+T
	(For coreoplasty by photocoagulation, see 66762)			

REPAIR

(For reposition or resection or uveal tissue with perforating wound of cornea or sclera, see 65285)

66680	Repair of iris, ciliary body (as for iridodialysis)	160.00	45	4.0+T
66682	Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture)	150.00	45	8.0+T

DESTRUCTION

66700	Ciliary body destruction; diathermy,	200.00	45	4.0+T
66710	cyclophotocoagulation, transscleral	200.00	45	4.0+T
66711	cyclophotocoagulation, endoscopic	200.00	90	4.0+T
66720	cryotherapy	200.00	45	4.0+T
66740	cyclodialysis	200.00	45	4.0+T
66761	Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (one or more sessions)	40.00	30	4.0+T
66762	Iridoplasty by photocoagulation (one or more sessions) (eg, for improvement of vision for widening of anterior chamber angle)	80.00	45	4.0+T
66770	Destruction of cyst or lesion iris or ciliary body (nonexcisional procedure)	BR	30	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
	(For excision lesion iris, ciliary body, see 66600, 66605)			
	(For removal epithelial downgrowth, see 65900)			
LENS				
	INCISION			
66820	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)	120.00	45	4.0+T
66821	laser surgery (eg, YAG laser) (one or more stages)	120.00	45	4.0+T
66825	Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)	170.00	45	4.0+T
	REMOVAL CATARACT			
	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)	120.00	45	4.0+T
66840	Removal of lens material; aspiration technique, one or more stages	240.00	30	4.0+T
66850	phacofragmentation technique (mechanical or ultrasonic,) (eg, phacoemulsification), with aspiration	240.00	30	4.0+T
66852	pars plana approach, with or without vitrectomy	240.00	30	4.0+T
66920	intracapsular	320.00	90	8.0+T
66930	intracapsular, for dislocated lens	320.00	90	8.0+T
66940	extracapsular (other than 66840, 66850, 66852)	320.00	90	8.0+T
	(For removal of intralenticular foreign body without lens extraction, see 65235)			
	(For repair of operative wound, see 66250)			
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	440.00	90	8.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	440.00	90	8.0+T
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)	440.00	90	8.0+T
	(For complex extracapsular cataract removal, use 66982)			
66985	Insertion of intraocular lens prosthesis (secondary implant)not associated with concurrent cataract removal	250.00	90	8.0+T
66986	Exchange of intraocular lens	250.00	90	8.0+T
	(To code implant at time of concurrent cataract surgery, use 66982, 66983 or 66984) (For ultrasonic determination of intraocular lens power, use 76519) (For removal of implanted material from anterior segment, use 65920): (For secondary fixation, use 66682)			
66990	Use of ophthalmic endoscope (List separately in addition to primary procedure) (66990 may be used only with codes 65820, 65875, 65920, 66985, 66986, 67038, 67039, 67040)	24.00		
66999	Unlisted procedure, anterior segment, eye	BR		8.0+T

POSTERIOR SEGMENT

VITREOUS

67005	Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal	440.00	90	8.0+T
67010	subtotal removal with mechanical vitrectomy	440.00	90	8.0+T
	(For removal of vitreous by paracentesis of anterior chamber, see 65810) (For removal of corneovitreal adhesions, see 65880)			
67015	Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)	120.00	15	4.0+T
67025	Injection of vitreous substitute, pars plana or limbal approach, (fluid-gas exchange), with or without aspiration (separate procedure)	200.00	60	8.0+T
67027	Implantation of intravitreal drug delivery system (eg, Ganciclovir implant), includes concomitant removal of vitreous	440.00	90	8.0+T
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	200.00	60	8.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
67030	Discission of vitreous strands (without removal), pars plana approach	440.00	90	8.0+T
67031	Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)	440.00	90	8.0+T
67036	Vitrectomy, mechanical, pars plana approach;	440.00	90	8.0+T
67038	with epiretinal membrane stripping	530.00	90	8.0+T
67039	with focal endolaser photocoagulation	500.00	90	8.0+T
67040	with endolaser panretinal photocoagulation	500.00	90	8.0+T

(For associated lensectomy, see 66850)
(For use of vitrectomy in retinal detachment surgery, see 67108)
(For associated removal of foreign body, see 65260, 65265)
(For use of ophthalmic endoscope with 67038, 67039, 67040, use 66990)

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	400.00	90	7.0+T
67105	photocoagulation with or without drainage of subretinal fluid	200.00	60	7.0+T
67107	Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photo-coagulation and drainage of subretinal fluid	400.00	90	7.0+T
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	530.00	90	7.0+T
67110	by injection of air or other gas (eg, pneumatic retinopexy)	250.00	90	7.0+T
67112	by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques	400.00	90	7.0+T

(For aspiration/drainage of subretinal/subchoroidal fluid, see 67015)

67115	Release of encircling material (posterior segment)	160.00	30	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
67120	Removal of implanted material, posterior segment; extraocular	120.00	30	4.0+T
67121	intraocular	160.00	30	4.0+T

(For removal of implanted material from anterior segment, use 65920)
(For removal of foreign body from posterior segment, see 65260, 65265)

PROPHYLAXIS

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	400.00	90	7.0+T
67145	photocoagulation (laser or xenon arc)	200.00	60	7.0+T

DESTRUCTION

67208	Destruction of localized lesion of retina (eg, macular edema, tumors) one or more sessions; cryotherapy, diathermy	160.00	30	4.0+T
67210	photocoagulation	160.00	30	4.0+T
67218	radiation by implantation of source (includes removal of source)	250.00	30	4.0+T
67220	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), one or more sessions	160.00	30	4.0+T
67221	photodynamic therapy (includes intravenous infusion)	160.00	30	4.0+T
67225	photodynamic therapy, second eye, at single session (List separately in addition to primary eye treatment) (Use 67225 in conjunction with code 67221)	80.00		
67227	Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; cryotherapy, diathermy	160.00	30	4.0+T
67228	photocoagulation (laser or xenon arc)	160.00	30	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES

SCLERAL

REPAIR

(For excision lesion sclera, see 66130)

67250	Scleral reinforcement (separate procedure); without graft	200.00	30	8.0+T
67255	with graft	210.00	30	8.0+T
	(For repair scleral staphyloma, see 66220, 66225)			
67299	Unlisted procedure, posterior segment	BR		8.0+T

OCULAR ADNEXA

EXTRAOCULAR MUSCLES

67311	Strabismus surgery, recession or resection procedure; one horizontal muscle	240.00	30	4.0+T
67312	two horizontal muscles	240.00	30	4.0+T
67314	one vertical muscle (excluding superior oblique)	240.00	30	4.0+T
67316	two or more vertical muscles (excluding superior oblique)	240.00	30	4.0+T
	(For adjustable sutures, use 67335 in addition to codes 67311-67334 for primary procedure reflecting number of muscles operated on)			
67318	Strabismus surgery, any procedure superior oblique muscle	240.00	30	4.0+T
	(Use 67320, 67331, 67332, 67335, 67340, 67343 in addition to code for primary strabismus surgery (67311-67318))			
67320	Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify)	280.00	30	4.0+T
67331	Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles	240.00	30	4.0+T
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)	240.00	30	4.0+T
67334	Strabismus surgery by posterior fixation suture technique, with or without muscle recession	240.00	30	4.0+T
67335	Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s)	240.00	30	4.0+T
	(List separately in addition to code for specific strabismus surgery)			
	(Use 67335 only for code(s) for conventional muscle surgery, 67311-67334, to identify number of muscles involved)			
67340	Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s)	240.00	30	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
67343	Release of extensive scar tissue without detaching extraocular muscle (separate procedure)	240.00	30	4.0+T
67345	Chemodenervation of extraocular muscle	40.00		3.0+T
	(For chemodenervation for blepharospasm and other neurological disorders, see 64612 and 64613)			
67350	Biopsy of extraocular muscle	40.00	15	3.0+T
	(For repair of wound, extraocular muscle, tendon or Tenon's capsule, see 65290)			
67399	Unlisted procedure, ocular muscle	BR		4.0+T

ORBIT

EXPLORATION, EXCISION, DECOMPRESSION

(For exenteration, enucleation, and repair, see 65101 et seq)

67400	Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy	240.00	30	7.0+T
67405	with drainage only	240.00	30	7.0+T
67412	with removal of lesion	240.00	30	7.0+T
67413	with removal of foreign body	240.00	30	7.0+T
67414	with removal of bone for decompression	240.00	30	7.0+T
67415	Fine needle aspiration of orbital contents	BR		4.0+T
	(For exenteration, enucleation, and repair, see 65101 et seq)			
	(For optic nerve decompression see 67570)			
67420	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion	360.00	30	7.0+T
67430	with removal of foreign body	360.00	30	7.0+T
67440	with drainage	360.00	30	7.0+T
67445	with removal of bone for decompression	360.00	30	7.0+T
67450	for exploration, with or without biopsy	360.00	30	7.0+T
	(For orbitotomy, transcranial approach, see 61330-61334)			
	(For orbital implant, see 67550, 67560)			
	(For optic nerve sheath decompression, see 67570)			
	(For removal of eyeball or for repair after removal, see 65091-65175)			

OTHER PROCEDURES

67500	Retrobulbar injection; medication (separate procedure, does not include supply of medication)	40.00		3.0+T
67505	alcohol	40.00	15	
67515	Injection of medication or other substance into Tenon's capsule	40.00		3.0+T
	(For subconjunctival injection, see 68200)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
67550	Orbital implant (implant outside muscle cone); insertion	240.00	30	4.0+T
67560	removal or revision	240.00	30	4.0+T
	(For ocular implant (implant inside muscle cone), see 65093-65105, 65130-65175)			
67570	Optic nerve decompression (eg, incision or fenestration of optic nerve sheath)	360.00	30	4.0+T
	(For treatment of fractures of malar area, orbit, see 21355 et seq)			
67599	Unlisted procedure, orbit	BR		4.0+T

EYELIDS

INCISION

67700	Blepharotomy, drainage of abscess, eyelid	8.00		3.0+T
67710	Severing of tarsorrhaphy	20.00	15	3.0+T
67715	Canthotomy (separate procedure)	100.00	30	3.0+T
	(For canthoplasty, see 67950) (For division of symblepharon, see 68340)			

EXCISION

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

(For removal of lesion, involving mainly skin of eyelid, see 11310-11313; 11440-11446; 11640-11646; 17000-17004)

(For repair of wounds, blepharoplasty, grafts, reconstructive surgery, see 67930-67975)

67800	Excision of chalazion; single	20.00	15	3.0+T
67801	multiple, same lid	24.00	15	3.0+T
67805	multiple, different lids	28.00	15	3.0+T
67808	under general anesthesia and/or requiring hospitalization, single or multiple	22.00	15	3.0+T
67810	Biopsy of eyelid	12.00	15	3.0+T
67820	Correction of trichiasis; epilation, by forceps only	16.00	15	3.0+T
67825	epilation by other than forceps (eg, by electrosurgery, cryotherapy, laser surgery)	100.00	30	3.0+T
67830	incision of lid margin	140.00	30	3.0+T
67835	incision of lid margin, with free mucous membrane graft	200.00	60	3.0+T
67840	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	20.00	15	3.0+T
	(For excision and repair of eyelid by reconstructive surgery, see 67961-67966)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
67850	Destruction of lesion of lid margin (up to 1 cm)	BR		3.0+T
	(For Mohs' micrographic surgery, see 17304-17310) (For initiation or follow-up care of topical chemotherapy, eg, 5-FU or similar agents, see appropriate office Evaluation and Management service)			
	TARSORRHAPHY			
67875	Temporary closure of eyelids by suture (eg, Frost suture)	8.00	15	3.0+T
67880	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;	100.00	60	3.0+T
67882	with transposition of tarsal plate	120.00	60	4.0+T
	(For severing of tarsorrhaphy, see 67710) (For canthoplasty, reconstruction canthus, see 67950) (For canthotomy, see 67715)			
	REPAIR(BROW PTOSIS, BLEPHAROPTOSIS, LID RETRACTION, ECTROPION)			
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	150.00	60	4.0+T
	(For forehead rhytidectomy, see 15824)			
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	100.00	60	3.0+T
67902	frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	240.00	60	4.0+T
67903	(tarso) levator resection or advancement, internal approach	240.00	60	4.0+T
67904	(tarso) levator resection or advancement, external approach	240.00	60	4.0+T
67906	superior rectus technique with fascial sling (includes obtaining fascia)	320.00	60	4.0+T
67908	conjunctivo-tarso-Muller's muscle-levator resection (Fasanella Servat type)	240.00	60	4.0+T
67909	Reduction of overcorrection of ptosis	150.00	60	4.0+T
67911	Correction of lid retraction	150.00	60	4.0+T
	(For obtaining autogenous graft material, see 20920, 20922 or 20926) (For correction trichiasis by mucous membrane graft, see 67835)			
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)	285.00	90	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
67914	Repair of ectropion; suture	160.00	30	4.0+T
67915	thermocauterization	20.00	15	4.0+T
67916	excision tarsal wedge	160.00	30	4.0+T
67917	extensive (eg, tarsal strip operations)	160.00	30	4.0+T

(For correction everted punctum, see 68705)

67921	Repair of entropion; suture	80.00	30	4.0+T
67922	thermocauterization	20.00	15	4.0+T
67923	excision tarsal wedge	160.00	30	4.0+T
67924	extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)	160.00	30	4.0+T

(For repair cicatricial ectropion or entropion requiring scar excision or skin graft, see also 67961 et seq)

RECONSTRUCTION

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

67930	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva, direct closure; partial thickness	100.00	30	4.0+T
67935	full thickness	160.00	30	4.0+T
67938	Removal of embedded foreign body, eyelid	20.00	15	3.0+T

(For repair of skin of eyelid, see 12011-12018; 12051-12057; 13150-13153)
(For repair of lacrimal canaliculi, see 68700)
(For tarsorrhaphy, canthorrhaphy, see 67880-67882)
(For repair of blepharoptosis and lid retraction, see 67901-67911)
(For blepharoplasty for entropion, ectropion, see 67916, 67917, 67923, 67924)
(For correction of blepharochalsis (blepharorhytidectomy), see 15820-15823)
(For repair of skin of eyelid, adjacent tissue transfer, see 14060, 14061; preparation for graft, see 15000; free graft, see 15120, 15121, 15260, 15261).
(For excision of lesion of eyelid, see 67800 et seq)

67950	Canthoplasty (reconstruction of canthus)	148.00	60	4.0+T
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	148.00	60	3.0+T
67966	over one-fourth of lid margin	200.00	60	3.0+T

(For tubed pedicle flap preparation, see 15576)
(For delay, see 15630)
(For attachment, see 15650)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
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	200.00	60	3.0+T
67973	total eyelid, lower, one stage or first stage	300.00	60	3.0+T
67974	total eyelid, upper, one stage or first stage	340.00	60	3.0+T
67975	second stage	200.00	60	3.0+T
67999	Unlisted procedure, eyelids	BR		4.0+T

CONJUNCTIVA

(For removal of foreign body, see 65205 et seq)

INCISION AND DRAINAGE

68020	Incision of conjunctiva, drainage of cyst	20.00	15	4.0+T
68040	Expression of conjunctival follicles (eg, for trachoma)	8.00		

EXCISION AND/OR DESTRUCTION

68100	Biopsy of conjunctiva	20.00	15	4.0+T
68110	Excision of lesion, conjunctiva; up to 1 cm	20.00	15	4.0+T
68115	over 1 cm	20.00	15	4.0+T
68130	with adjacent sclera	BR	30	5.0+T
68135	Destruction of lesion, conjunctiva	20.00	15	4.0+T

INJECTION

(For injection into Tenon's capsule or retrobulbar injection, see 67500-67515)

68200	Subconjunctival injection	5.00		3.0+T

CONJUNCTIVOPLASTY

(For wound repair, see 65270-65273)

68320	Conjunctivoplasty; with conjunctival graft or extensive rearrangement	200.00	30	5.0+T
68325	with buccal mucous membrane graft (includes obtaining graft)	240.00	30	5.0+T
68326	Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement	240.00	30	5.0+T
68328	with buccal mucous membrane graft (includes obtaining graft)	240.00	30	5.0+T
68330	Repair of symblepharon; conjunctivoplasty, without graft	150.00	30	5.0+T
68335	with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)	150.00	30	5.0+T
68340	division of symblepharon with or without insertion of conformer or contact lens	150.00	30	5.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
OTHER PROCEDURES				
68360	Conjunctival flap; bridge or partial (separate procedure)	80.00	30	4.0+T
68362	total (such as Gunderson thin flap or purse string flap)	250.00	90	4.0+T
	(For conjunctival flap for perforating injury, see 65280, 65285)			
	(For repair of operative wound, see 66250)			
	(For removal of conjunctival foreign body, see 65205, 65210)			
68399	Unlisted procedure, conjunctiva	BR		5.0+T
LACRIMAL SYSTEM				
INCISION				
68400	Incision, drainage of lacrimal gland	40.00	15	4.0+T
68420	Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy)	30.00	15	4.0+T
68440	Snip incision of lacrimal punctum	30.00	15	4.0+T
EXCISION				
68500	Excision of lacrimal gland (dacryoadenectomy), except for tumor; total	200.00	45	4.0+T
68505	partial	200.00	45	4.0+T
68510	Biopsy of lacrimal gland	20.00	15	4.0+T
68520	Excision of lacrimal sac (dacryocystectomy)	200.00	45	4.0+T
68525	Biopsy of lacrimal sac	20.00	15	4.0+T
68530	Removal of foreign body or dacryolith, lacrimal passages	80.00	15	3.0+T
68540	Excision of lacrimal gland tumor; frontal approach	240.00	45	4.0+T
68550	involving osteotomy	240.00	45	4.0+T
REPAIR				
68700	Plastic repair of canaliculi	200.00	60	4.0+T
68705	Correction of everted punctum, cautery	16.00	15	3.0+T
68720	Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)	280.00	60	5.0+T
68745	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube	280.00	60	5.0+T
68750	with insertion of tube or stent	280.00	60	5.0+T
68760	Closure of lacrimal punctum; by thermocauterization, ligation, or laser surgery	16.00	15	3.0+T
68761	by plug, each	16.00	15	3.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
68770	Closure of lacrimal fistula (separate procedure)	16.00	15	3.0+T
	PROBING AND/OR RELATED PROCEDURES			
68801	Dilation of lacrimal punctum, with or without irrigation	8.00		3.0+T
68810	Probing of nasolacrimal duct, with or without irrigation;	12.00		3.0+T
68811	requiring general anesthesia	12.00		3.0+T
68815	with insertion of tube or stent (see also 92018)	40.00	15	3.0+T
68840	Probing of lacrimal canaliculi, with or without irrigation	8.00		3.0+T
68850	Injection of contrast medium for dacryocystography (For radiological supervision and interpretation, see 70170, 78660)	12.00		
68899	Unlisted procedure, lacrimal system	BR		4.0+T

AUDITORY SYSTEM

(For diagnostic services, eg, audiometry, vestibular tests, see 92502 et seq)

EXTERNAL EAR

INCISION

69000	Drainage external ear, abscess or hematoma; simple	8.00		3.0+T
69005	complicated	20.00	30	3.0+T
69020	Drainage external auditory canal, abscess	8.00		3.0+T

EXCISION

(For reconstruction of ear, see 15120 et seq)

(For skin grafting, see 15000-15261)

69100	Biopsy external ear	12.00	15	3.0+T
69105	Biopsy external auditory canal	12.00	15	3.0+T
69110	Excision external ear; partial, simple repair	40.00	30	3.0+T
69120	complete amputation	80.00	90	3.0+T
69140	Excision exostosis(es), external auditory canal	200.00	90	3.0+T
69145	Excision soft tissue lesion, external auditory canal	20.00		
69150	Radical excision external auditory canal lesion; without neck dissection	380.00	90	4.0+T
69155	with neck dissection	500.00	90	6.0+T

(For resection of temporal bone, see 69535)

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
REMOVAL OF FOREIGN BODY				
69200	Removal foreign body from external auditory canal; without general anesthesia	8.00		
69205	with general anesthesia	8.00		3.0+T
69220	Debridement, mastoidectomy cavity, simple (eg, routine cleaning)	40.00	30	3.0+T
69222	Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)	80.00	30	3.0+T
REPAIR				
	(For suture of wound or injury of external ear, see 12011-14300)			
	(For other reconstructive procedures with grafts (skin, cartilage, bone), see 13150-15760, 21230-21235)			
69300	Otoplasty, protruding ear, with or without size reduction	200.00	180	3.0+T
69310	Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection), separate procedure	400.00	180	4.0+T
69320	Reconstruction of external auditory canal for congenital atresia, single stage	400.00	180	3.0+T
	(For combination with middle ear reconstruction, see 69631, 69641) (For otoscopy under general anesthesia, see 92502)			
69399	Unlisted procedure, external ear	BR		3.0+T
MIDDLE EAR				
INTRODUCTION				
69400	Eustachian tube inflation, transnasal; with catheterization	6.00		3.0+T
69401	without catheterization	6.00		3.0+T
69405	Eustachian tube catheterization, transtympanic	6.00		3.0+T
INCISION				
69420	Myringotomy including aspiration and/or eustachian tube inflation	12.00		
69421	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia	12.00	7	3.0+T
69433	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia	20.00	7	

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	100.00	45	3.0+T
69440	Middle ear exploration through postauricular or ear canal incision	200.00	30	3.0+T
	(For atticotomy, see 69601 et seq)			
69450	Tympanolysis, transcanal	320.00	180	3.0+T
EXCISION				
69501	Transmastoid antrotomy (simple mastoidectomy)	200.00	180	4.0+T
69502	Mastoidectomy; complete	320.00	180	4.0+T
69505	modified radical	320.00	180	4.0+T
69511	radical	360.00	180	4.0+T
	(For mastoidectomy cavity debridement, see 69220-69222)			
69530	Petrous apicectomy including radical mastoidectomy	500.00	90	4.0+T
69535	Resection temporal bone, external approach	BR		3.0+T
	(For middle fossa approach, see 69950-69970)			
69540	Excision aural polyp	40.00	30	3.0+T
69550	Excision aural glomus tumor; transcanal	200.00	90	3.0+T
69552	transmastoid	380.00	90	4.0+T
69554	extended (extratemporal)	530.00	90	4.0+T
REPAIR				
(For skin graft, see 15120, 15121, 15260, 15261)				
69601	Revision mastoidectomy; resulting in complete mastoidectomy	360.00	180	4.0+T
69602	resulting in modified radical mastoidectomy	360.00	180	4.0+T
69603	resulting in radical mastoidectomy	360.00	180	4.0+T
69604	resulting in tympanoplasty	400.00	180	4.0+T
	(For planned secondary tympanoplasty after mastoidectomy,see 69631, 69632)			
69605	with apicectomy	500.00	90	4.0+T
69610	Tympanic membrane repair, with or without site preparation or perforation for closure, with or without patch	8.00		3.0+T
69620	Myringoplasty (surgery confined to drumhead and donor area)	320.00	180	4.0+T
69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	400.00	180	4.0+T
69632	with ossicular chain reconstruction, (eg, postfenestration)	600.00	180	4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
69633	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision;with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, (PORP), total ossicular replacement prosthesis, (TORP))	600.00	180	4.0+T
69635	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction	600.00	180	4.0+T
69636	with ossicular chain reconstruction	680.00	180	4.0+T
69637	with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, (PORP), total ossicular replacement prosthesis, (TORP))	680.00	180	4.0+T
69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction	480.00	180	4.0+T
69642	with ossicular chain reconstruction	680.00	180	4.0+T
69643	with intact or reconstructed wall, without ossicular chain reconstruction	480.00	180	4.0+T
69644	with intact or reconstructed canal wall, with ossicular chain reconstruction	680.00	180	4.0+T
69645	radical or complete, without ossicular chain reconstruction	480.00	180	4.0+T
69646	radical or complete, with ossicular chain reconstruction	680.00	180	4.0+T
69650	Stapes mobilization	280.00	90	4.0+T
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;	400.00	90	4.0+T
69661	with footplate drill out	650.00	90	4.0+T
69662	Revision of stapedectomy or stapedotomy	400.00	90	4.0+T
69666	Repair oval window fistula	410.00	90	4.0+T
69667	Repair round window fistula	410.00	90	4.0+T
69670	Mastoid obliteration (separate procedure)	320.00	90	4.0+T
69676	Tympanic neurectomy	180.00	90	4.0+T

OTHER PROCEDURES

69700	Closure postauricular fistula, mastoid (separate procedure)	100.00	60	4.0+T
69710	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone (Replacement procedure includes removal of old device)	380.00	180	4.0+T
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	BR		4.0+T

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	340.00	180	4.0+T
69715	with mastoidectomy	400.00	180	4.0+T
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	350.00	180	4.0+T
69718	with mastoidectomy	400.00	180	4.0+T
69720	Decompression facial nerve, intratemporal; lateral to geniculate ganglion	400.00	180	9.0+T
69725	including medial to geniculate ganglion	400.00	180	9.0+T
69740	Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion	480.00	180	9.0+T
69745	including medial to geniculate ganglion	480.00	180	9.0+T
	(For extracranial suture of facial nerve, see 64864)			
69799	Unlisted procedure, middle ear	BR		4.0+T

INNER EAR

INCISION AND/OR DESTRUCTION

69801	Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); transcanal (69801 includes all required infusions performed on initial and subsequent days of treatment)	400.00	180	6.0+T
69802	with mastoidectomy	500.00	180	6.0+T
69805	Endolymphatic sac operation; without shunt	500.00	180	6.0+T
69806	with shunt	500.00	180	6.0+T
69820	Fenestration semicircular canal	400.00	180	6.0+T
69840	Revision fenestration operation	240.00	180	6.0+T

EXCISION

69905	Labyrinthectomy; transcanal	400.00	180	6.0+T
69910	with mastoidectomy	500.00	180	6.0+T
69915	Vestibular nerve section, translabyrinthine approach	BR	180	6.0+T
	(For transcranial approach, see 69950)			

CODE	DESCRIPTION	FEE	F/U DAYS	ANES
INTRODUCTION				
69930	Cochlear device implantation, with or without mastoidectomy	380.00		6.0+T
69949	Unlisted procedure, inner ear	BR		6.0+T
TEMPORAL BONE, MIDDLE FOSSA APPROACH				
(For external approach, see 69535)				
69950	Vestibular nerve section, transcranial approach	BR		6.0+T
69955	Total facial nerve decompression and/or repair (may include graft)	500.00	180	6.0+T
69960	Decompression internal auditory canal	500.00	180	6.0+T
69970	Removal of tumor, temporal bone	550.00	180	6.0+T
69979	Unlisted procedure, temporal bone, middle fossa approach	BR		6.0+T

RADIOLOGY SECTION

GENERAL INSTRUCTIONS

Listed fees represent maximum allowances for reimbursement purposes in the Medical Assistance Program and include the administrative, technical and professional components of the service provided. To determine the fee applicable only to the professional component, multiply the listed dollar value by a maximum conversion factor of 40%. (See below for further reference to the administrative, technical and professional components of a radiology fee item.)

Fees attached hereto are to be considered as payment for the complete radiological procedure, unless otherwise indicated. In order to be paid for both the professional and the technical and administrative components of the radiology service, qualified practitioners who provide radiology services in their offices must perform the professional component of radiology services and own or directly lease the equipment and must supervise and control the radiology technician who performs the radiology procedures; or be the employees of physicians who own or directly lease the equipment and must supervise and control the radiology technician who performs the radiology procedures.

Each State agency may determine, on an individual basis, fees for services or procedures not included in this fee schedule. Such fee determinations should be reported promptly to the Division of Health Care Financing of the State Department of Health for review by the Interdepartmental Committee on Health Economics for possible incorporation in the Radiology Fee Schedule.

TECHNICAL, ADMINISTRATIVE AND PROFESSIONAL RADIOLOGY COMPONENTS

When radiological services are rendered in hospital departments by radiologists who receive no salary/ compensation from the facility for patient care and who bill separately, the charge for the professional component may not exceed 40% of the maximum fee in the Radiology Services Fee Schedule. The remaining 60% of the fee is the maximum amount applicable for the technical and administrative services provided by the hospital. No payment will be made to a qualified practitioner solely for the technical and administrative component of radiology services. (See modifier -TC for the technical component.)

The professional component (see modifier -26) for radiological services is intended to cover professional services, when applicable, as listed below:

1. Determination of the problem, including interviewing the patient, obtaining the history and making appropriate physical examination to determine the method of performing the radiologic procedure.

2. Study and evaluation of results obtained in diagnostic or therapeutic procedures, interpretation of radiographs or radioisotope data-estimation resultant from treatment.

3. Dictating report of examination or treatment.

4. Consultation with referring physician regarding results of diagnostic or therapeutic procedures.

The technical or administrative component (see modifier -TC) includes items such as: cost or charges for technologists, clerical staff, films, opaques, radioactive materials, chemicals, drugs or other materials, purchase, rental use or maintenance of space, equipment, telephone services or other facilities or supplies.

Certain radiological procedures require the performance of a medical or surgical procedure (eg, studies necessitating an injection of radiopaque media, fluoroscopy, consultation) which must be performed by the radiologist and is not separable into technical and professional components for billing purposes. In these instances, the total fee listed in the Medicine or Surgery Services Fee Schedule is applicable.

GENERAL INFORMATION AND RULES

General rules which apply to all procedure codes in the Radiology Services Fee Schedule sections of Diagnostic Radiology, Diagnostic Ultrasound, Radiation Oncology and Nuclear Medicine are as follows:

1. Dollar values include usual contrast media, equipment and materials. An additional charge may be warranted when special surgical trays and materials are provided by the physician.

2. Dollar values include consultation and a written report to the referring physician.

3. When multiple X-ray examinations are performed during the same visit, reimbursement shall be limited to the greater fee plus 60% of the lesser fee(s). When more than one part of the body is included in a single X-ray for which reimbursement is claimed, the charge shall be only for a single X-ray. When bilateral X-ray examinations are performed during the same visit, reimbursement shall be limited to 160% of the procedure value (see modifier -50). The above provisions regarding fee reductions for multiple X-rays are applicable to X-rays taken of all parts of the body.

4. When repeat X-ray examinations of the same part and for the same illness are required because of technical or professional error in the original X-rays, such repeat X-rays are not eligible for payment. (See Rule 5 below.)

5. When repeat X-ray examination of the same part and for the same illness is required for reasons other than technical or professional error in the original X-ray. It should be identified by use of modifier -76.

6. RADIOLOGICAL SUPERVISION AND INTERPRETATION CODES: The MAXIMUM FEE-NYS is applicable when the physician incurs the costs of both the technical /administrative and professional components of the imaging procedure. (For the professional component of radiologic procedures, see modifier -26). When a procedure is performed by two physicians, the radiologic portion of the procedure is designated as "radiological supervision and interpretation." When a physician performs both the procedure and provides imaging supervision and interpretation, a combination of procedure codes outside the 70000 series and imaging supervision and interpretation codes are to be used.

7. BY REPORT**:** A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are: complexity of symptoms, final diagnosis, pertinent physical findings (such as size, locations, and number of lesion(s), if appropriate), diagnostic and therapeutic procedures including major and supplementary surgical procedures, if appropriate), concurrent problems, and follow-up care.

   When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service must be furnished in addition to the time, skill and equipment necessitated. Appropriate documentation (eg, procedure description, itemized invoices, etc) should accompany all claims submitted.

   Itemized invoices must document acquisition cost, the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations.

8. SEPARATE PROCEDURES**:** Some of the listed procedures are commonly carried out as an integral part of a total service, and as such, do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a "separate procedure." Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be reported as a separate procedure.

MMIS MODIFIERS: RADIOLOGY SECTION

-26 Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier -26 to the usual procedure number. (Reimbursement will not exceed 40% of the maximum State Medical Fee Schedule amount.)

-TC Technical Component: Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier -TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. (Reimbursement will not exceed 60% of the maximum State Medical Fee Schedule amount.)

-50 Bilateral Procedures (X-ray): When bilateral X-ray examinations are performed, the service will be identified by adding the modifier -50 to the usual procedure code number. (Reimbursement will not exceed 160% of the maximum State Medical Fee Schedule amount. One claim line is to be billed representing the bilateral procedure. Amount billed should reflect total amount due.)

-76 Repeat X-ray Procedure: When a repeat X-ray examination of the same part and for the same illness is required for reasons other than technical or professional error in the original X-ray, it will be identified by adding modifier -76. (Reimbursement will not exceed 100% of the maximum State Medical 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 using the modifier -79 to the related procedure. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-FP Service Provided as Part of Family Planning Program: All Family Planning Services will be identified by adding the modifier -FP to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-99 Multiple Modifiers: Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier -99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

CODE	DESCRIPTION	FEE

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

HEAD AND NECK

(For injection procedure: myelography, see 61055, 62284; cisternography, see 61055, 62284; dacryocystography, see 68850; arthrotomography, see 21116; laryngography, see 31708; sialography, see 42550)

(To report CT guidance for stereotactic localization, use 76355; for corneal, sagittal, and/or oblique sections, see 76375; for cervical spine, see 72125, 72126)

70010	Myelography, posterior fossa; radiological supervision and interpretation	62.50
70015	Cisternography, positive contrast; radiological supervision and interpretation	75.00
70030	Radiologic examination, eye, for detection of foreign body	40.00
70100	Radiologic examination, mandible; partial, less than four views	15.00
70110	complete, minimum of four views	25.00
70120	Radiologic examination, mastoids; less than three views per side	15.00
70130	complete, minimum of three views per side	25.00
70134	Radiologic examination, internal auditory meati, complete	25.00
70140	Radiologic examination, facial bones; less than three views	15.00
70150	complete, minimum of three views	25.00
70160	Radiologic examination, nasal bones, complete, minimum of three views	15.00
70170	Dacryocystography, nasolacrimal duct; radiological supervision and interpretation	20.00
70190	Radiologic examination; optic foramina	15.00
70200	orbits, complete, minimum of four views	25.00
70210	Radiologic examination, sinuses, paranasal; less than three views	12.50
70220	complete, minimum of three views	20.00
70240	Radiologic examination, sella turcica	12.50
70250	Radiologic examination, skull; less than four views	15.00
70260	complete, minimum of four views	25.00
70300	Radiologic examination, teeth; single view	5.00
70310	partial examination, less than full mouth	10.00
70320	complete, full mouth	15.00
70328	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	12.50
70330	bilateral	20.00
70332	Temporomandibular joint arthrography; radiological supervision and interpretation (Do not report 76003 in addition to 70332)	35.00
70336	Magnetic resonance (eg, proton) imaging, temporomandibular joints	500.00
70350	Cephalogram, orthodontic	10.00
70355	Orthopantogram	13.00
70360	Radiologic examination; neck, soft tissue	10.00
70370	pharynx or larynx, including fluoroscopy and/or magnification technique	25.00

CODE	DESCRIPTION	FEE
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	35.00
70373	Laryngography, contrast; radiological supervision and interpretation	25.00
70380	Radiologic examination, salivary gland for calculus	15.00
70390	Sialography; radiological supervision and interpretation	20.00
70450	Computed tomography, head or brain; without contrast material	120.00
70460	with contrast material(s)	145.00
70470	without contrast material, followed by contrast material(s) and further sections	217.00
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	120.00
70481	with contrast material(s)	145.00
70482	without contrast material, followed by contrast material(s) and further sections	217.00
70486	Computed tomography, maxillofacial area; without contrast material	120.00
70487	with contrast material(s)	145.00
70488	without contrast material, followed by contrast material(s) and further sections	217.00
70490	Computed tomography, soft tissue neck; without contrast material	140.00
70491	with contrast material(s)	170.00
70492	without contrast material, followed by contrast material(s) and further sections	254.00
70496	Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	217.00
70498	Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	254.00
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and neck; without contrast material(s)	500.00
70542	with contrast material(s)	500.00
70543	without contrast material(s), followed by contrast material(s) and further sequence	500.00
70544	Magnetic resonance angiography, head; without contrast material(s)	500.00
70545	with contrast material(s)	500.00
70546	without contrast material(s), followed by contrast material(s) and further sequences	500.00
70547	Magnetic resonance angiography, neck; without contrast material(s)	500.00
70548	with contrast material(s)	500.00
70549	without contrast material(s), followed by contrast material(s) and further sequences	500.00
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	500.00
70552	with contrast material(s)	500.00
70553	without contrast material, followed by contrast material(s) and further sequences	500.00

CODE	DESCRIPTION	FEE
70557	Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material	500.00
70558	with contrast material(s)	500.00
70559	without contrast material(s), followed by contrast material(s) and further sequences	500.00

CHEST

(For chest fluoroscopy (separate procedure), see 76000)

(For biopsy procedure, see 32400 or 32405, 76003)

(For injection procedure only for bronchography, see 31656, 31708, 31710, 31715)

(For CT coronal, sagittal, and/or oblique sections, see 76375)

71010	Radiologic examination, chest; single view, frontal	10.00
71015	stereo, frontal	15.00
71020	Radiologic examination, chest, two views, frontal and lateral;	15.00
71021	with apical lordotic procedure	17.50
71022	with oblique projections	20.00
71023	with fluoroscopy	20.00
71030	Radiologic examination, chest, complete, minimum of four views;	20.00
71034	with fluoroscopy	20.00
71035	Radiologic examination, chest, special views, (eg, lateral decubitus, Bucky studies)	15.00
71040	Bronchography, unilateral, radiological supervision and interpretation	35.00
71060	Bronchography, bilateral, radiological supervision and interpretation	40.00
71090	Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation	30.00
71100	Radiologic examination, ribs, unilateral; two views	15.00
71101	including posteroanterior chest, minimum of three views	17.50
71110	Radiologic examination, ribs, bilateral; three views	25.00
71111	including posteroanterior chest, minimum of four views	27.50
71120	Radiologic examination; sternum, minimum of two views	15.00
71130	sternoclavicular joint or joints, minimum of three views	20.00
71250	Computed tomography, thorax; without contrast material	140.00
71260	with contrast material(s)	170.00
71270	without contrast material, followed by contrast material(s) and further sections	254.00
71275	Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	140.00

CODE	DESCRIPTION	FEE
71550	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)	500.00
71551	with contrast material(s)	500.00
71552	without contrast material(s), followed by contrast material(s) and further sequences	500.00
	(For breast MRI, see 76093 and 76094)	
71555	Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)	500.00

SPINE AND PELVIS

(IV injection of contrast material is part of the CT procedure. For intrathecal injection procedure, see 61055, 62284; diskography, see 62290, 62291; for CT coronal,sagittal, and/or oblique sections, see 76375)

72010	Radiologic examination, spine, entire, survey study, anteroposterior and lateral	40.00
72020	Radiologic examination, spine, single view, specify level	10.00
72040	Radiologic examination, spine, cervical; two or three views	15.00
72050	minimum of four views	20.00
72052	complete, including oblique and flexion and/or extension studies	30.00
72069	Radiologic examination, spine, thoracolumbar, standing (scoliosis)	15.00
72070	Radiologic examination, spine; thoracic, two views	15.00
72072	thoracic, three views	30.00
72074	thoracic, minimum of four views	30.00
72080	thoracolumbar, two views	15.00
72090	scoliosis study, including supine and erect studies	40.00
72100	Radiologic examination, spine, lumbosacral; two or three views	15.00
72110	minimum of four views	30.00
72114	complete, including bending views	30.00
72120	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	20.00
72125	Computed tomography, cervical spine; without contrast material	140.00
72126	with contrast material(s)	170.00
72127	without contrast material, followed by contrast material(s) and further sections	254.00
72128	Computed tomography, thoracic spine; without contrast material	140.00
72129	with contrast material(s)	170.00
72130	without contrast material, followed by contrast material(s) and further sections	254.00
72131	Computed tomography, lumbar spine; without contrast material	140.00
72132	with contrast material(s)	170.00
72133	without contrast material, followed by contrast material(s) and further sections	254.00

CODE	DESCRIPTION	FEE
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material(s)	500.00
72142	with contrast material(s) (For cervical spinal canal imaging without contrast material followed by contrast material, use 72156)	500.00
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material(s)	500.00
72147	with contrast material(s) (For thoracic spinal canal imaging without contrast material followed by contrast material, use 72157)	500.00
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	500.00
72149	with contrast material(s) (For lumbar spinal canal imaging without contrast material followed by contrast material, use 72158)	500.00
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	500.00
72157	thoracic	500.00
72158	lumbar	500.00
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)	500.00
72170	Radiologic examination, pelvis; one or two views	12.50
72190	complete, minimum of three views	20.00
	(For pelvimetry, see 74710)	
72191	Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	254.00
	(For CTA aorta-iliofemoral runoff, use 75635)	
72192	Computed tomography, pelvis; without contrast material	140.00
72193	with contrast material(s)	170.00
72194	without contrast material, followed by contrastmaterial(s) and further sections	254.00
72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)	500.00
72196	with contrast material(s)	500.00
72197	without contrast material(s), followed by contrast material(s) and further sequences	500.00
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)	500.00
72200	Radiologic examination, sacroiliac joints; less than three views	12.50
72202	three or more views	20.00
72220	Radiologic examination, sacrum and coccyx, minimum of two views	15.00

CODE	DESCRIPTION	FEE
72240	Myelography, cervical, radiological supervision and interpretation	40.00
72255	Myelography, thoracic, radiological supervision and interpretation	40.00
72265	Myelography, lumbosacral, radiological supervision and interpretation	40.00
72270	Myelography, two or more regions (eg, lumbar/thoracic, cervical/ thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation	60.00
72275	Epidurography, radiological supervision and interpretation	60.00
	(For injection procedure, see 62280-62282, 62310-62319, 64479-64484)	
72285	Diskography, cervical or thoracic, radiological supervision and interpretation	50.00
72295	Diskography, lumbar, radiological supervision and interpretation	50.00

UPPER EXTREMITIES

(For injection procedure, arthrography, see 23350, 24220, 25246)

73000	Radiologic examination; clavicle, complete	10.00
73010	scapula, complete	15.00
73020	Radiologic examination, shoulder; one view	10.00
73030	complete, minimum of two views	15.00
73040	Radiologic examination, shoulder, arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73040)	25.00
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	17.50
73060	humerus, minimum of two views	10.00
73070	Radiologic examination, elbow; two views	10.00
73080	complete, minimum of three views	12.50
73085	Radiologic examination, elbow, arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73085)	25.00
73090	Radiologic examination; forearm, two views	10.00
73092	upper extremity, infant, minimum of two views	10.00
73100	Radiologic examination, wrist; two views	10.00
73110	complete, minimum of three views	12.50
73115	Radiologic examination, wrist, arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73115)	25.00
73120	Radiologic examination, hand; two views	10.00
73130	minimum of three views	12.50
73140	Radiologic examination, finger(s), minimum of two views	7.50
73200	Computed tomography, upper extremity; without contrast material	140.00
73201	with contrast material(s)	170.00
73202	without contrast material, followed by contrast material(s) and further sections	254.00

CODE	DESCRIPTION	FEE
73206	Computed tomographic angiography, upper extremity, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	254.00
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)	500.00
73219	with contrast material(s)	500.00
73220	without contrast material(s), followed by contrast material(s) and further sequences	500.00
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	500.00
73222	with contrast material(s)	500.00
73223	without contrast material(s), followed by contrast material(s) and further sequences	500.00
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s)	500.00

LOWER EXTREMITIES

(For injection procedure, arthrography, see 27093, 27095, 27370, 27648)

73500	Radiologic examination, hip; unilateral, one view	12.50
73510	complete, minimum of two views	20.00
73520	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis	24.00
73525	Radiologic examination, hip, arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73525)	25.00
73530	Radiologic examination, hip, during operative procedure	30.00
73540	Radiologic examination, pelvis and hips, infant or child, minimum of two views	15.00
73542	Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73542) (For procedure, use 27096. If formal arthrography is not performed, recorded, and a formal radiologic report is not issued, use 76005 for fluoroscopic guidance for sacroiliac joint injections)	25.00
73550	Radiologic examination, femur, two views	15.00
73560	Radiologic examination, knee; one or two views	10.00
73562	three views	15.00
73564	complete, four or more views	20.00
73565	both knees, standing, anteroposterior	10.00
73580	Radiologic examination, knee, arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73580)	25.00
73590	Radiologic examination; tibia and fibula, two views	10.00
73592	lower extremity, infant, minimum of two views	15.00

CODE	DESCRIPTION	FEE
73600	Radiologic examination, ankle; two views	10.00
73610	complete, minimum of three views	12.50
73615	Radiologic examination, ankle, arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73615)	25.00
73620	Radiologic examination, foot; two views	10.00
73630	complete, minimum of three views	12.50
73650	Radiologic examination; calcaneus, minimum of two views	10.00
73660	toe(s), minimum of two views	7.50
73700	Computed tomography, lower extremity; without contrast material	140.00
73701	with contrast material(s)	170.00
73702	without contrast material, followed by contrast material(s) and further sections	254.00
73706	Computed tomographic angiography, lower extremity, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	254.00
73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)	500.00
73719	with contrast material(s)	500.00
73720	without contrast material(s), followed by contrast material(s) and further sequence	500.00
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material	500.00
73722	with contrast material(s)	500.00
73723	without contrast material(s), followed by contrast material(s) and further sequences	500.00
73725	Magnetic resonance angiography, lower extremity, with or without contrast material(s)	500.00
	(For CTA aorto-iliofemoral runoff, use 75635)	

ABDOMEN

74000	Radiologic examination, abdomen; single anteroposterior view	10.00
74010	anteroposterior and additional oblique and cone views	15.00
74020	complete, including decubitus and/or erect views	20.00
74022	complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest	26.00
74150	Computed tomography, abdomen; without contrast material	140.00
74160	with contrast material(s)	170.00
74170	without contrast material, followed by contrast material(s) and further sections	254.00
74175	Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	254.00
	(For CTA aorto-iliofemoral runoff, use 75635)	

CODE	DESCRIPTION	FEE
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)	500.00
74182	with contrast material(s)	500.00
74183	without contrast material(s), followed by contrast material(s) and further sequences	500.00
74185	Magnetic resonance angiography, abdomen, with or without contrast material(s)	500.00
74190	Peritoneogram (eg, after injection of air or contrast), radiological supervision and interpretation	19.00

(For procedure, see 49400)
(For computerized axial tomography, see 72192 or 74150)

GASTROINTESTINAL TRACT

(For percutaneous placement of gastrotomy tube, see 43750)

(For biliary duct stone extraction, percutaneous, see 47630, 74327)

74210	Radiologic examination; pharynx and/or cervical esophagus	20.00
74220	esophagus	20.00
74230	Swallowing function, with cineradiography/videoradiography	20.00
74235	Removal of foreign body(s), esophageal, with use of balloon catheter, radiological supervision and interpretation	60.00

(For procedure, see 43215, 43247)

74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	30.00
74241	with or without delayed films, with KUB,	35.00
74245	with small intestine, includes multiple serial films	40.00
74246	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, without KUB	50.00
74247	with or without delayed films, with KUB	60.00
74249	with small intestine follow-through	70.00
74250	Radiologic examination, small intestine, includes multiple serial films;	30.00
74251	via enteroclysis tube	30.00
74260	Duodenography, hypotonic	40.00
74270	Radiologic examination, colon; barium enema, with or without KUB	25.00
74280	air contrast with specific high density barium, with or without glucagon	40.00
74283	Therapeutic enema, contrast or air, for reduction of intussusception or other intraluminal obstruction (eg, meconium ileus)	25.00
74290	Cholecystography, oral contrast;	20.00
74291	additional or repeat examination or multiple day examination	20.00

CODE	DESCRIPTION	FEE
74300	Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	30.00
74301	additional set intraoperative, radiological supervision and interpretation (Use 74301 in conjunction with code 74300)	18.00
74305	through existing catheter, radiological supervision and interpretation	22.50
	(For procedure, see 47505, 48400, 47560-47561, 47563) (For biliary duct stone extraction, percutaneous, see 47630, 74327)	
74320	Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation	25.00
	(For injection procedure, transhepatic cholangiography, percutaneous, see 47500)	
74327	Postoperative biliary duct calculus removal, percutaneous via T-tube tract, basket or snare (eg, Burhenne technique), radiological supervision and interpretation	55.00
	(For procedure, see 47630)	
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	30.00
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	30.00
	(For procedure, see 43260-43272 as appropriate)	
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	36.00
	(For cholangiopancreatography (ERCP), see 43260-43272)	
74340	Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation	20.00
	(For tube placement, see 44500)	
74350	Percutaneous placement of gastrostomy tube; radiological supervision and interpretation	30.00
74355	Percutaneous placement of enteroclysis tube, radiological supervision and interpretation	40.00
	(For procedure, see 44015)	
74360	Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretation	40.00
	(For procedure, see 43220, 43458)	

CODE	DESCRIPTION	FEE
74363	Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation	80.00
	(For procedure, see 47510, 47511, 47555, 47556)	

URINARY TRACT

(For injection procedure: urography, see 50394, 50684, 50690; cystography, see 51600, 51605; vasography etc., see 52010, 55300; cavernosography, see 54230; urethrocystography, see 51600, 51610; cyst study, see 50390)

(For introduction only of catheter, stent or guide into renal pelvis and/or ureter, see 50392-50398)

74400	Urography (pyelography), intravenous, with or without KUB, with or without tomography;	35.00
74410	Urography, infusion, drip technique and/or bolus technique;	45.00
74415	with nephrotomography	75.00
74420	Urography, retrograde, with or without KUB	25.00
74425	Urography, antegrade, (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation	20.00
74430	Cystography, minimum of three views, radiological supervision and interpretation	20.00
74440	Vasography, vesiculography, or epididymography, radiological supervision and interpretation	45.00
74445	Corpora cavernosography, radiological supervision and interpretation	50.00
74450	Urethrocystography, retrograde, radiological supervision and interpretation	20.00
74455	Urethrocystography, voiding, radiological supervision and interpretation	35.00
74470	Radiologic examination, renal cyst study, translumbar, contrast visualization, radiological supervision and interpretation	20.00
74475	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation	50.00
74480	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation	75.00
	(For transurethral surgery (ureter and pelvis), see 52320-52355)	
74485	Dilation of nephrostomy, ureters or urethra, radiological supervision and interpretation	50.00
	(For dilation of stricture in the male ureter or urethra, see 53600-53621) (For dilation of ureter without radiologic guidance, use 52341-52344)	

CODE	DESCRIPTION	FEE

GYNECOLOGICAL AND OBSTETRICAL

(For abdomen and pelvis, see 74000-74170, 72170, 72190)

(For injection procedure only for hysterosalpingography, see 58340)

74710	Pelvimetry, with or without placental localization	25.00
74740	Hysterosalpingography, radiological supervision and interpretation	25.00
74742	Transcervical catheterization of fallopian tube, radiological supervision and interpretation	57.00
74775	Perineogram (eg, vaginogram, for sex determination or extent of anomalies)	30.00

HEART

(For injection procedures, vascular radiology, see 36000-36299; for intravenous procedures, see 36400-36425; for intra-arterial procedures, see 36100-36248 for cardiac catheterization procedures, see 93501-93556)

75552	Cardiac magnetic resonance imaging for morphology; without contrast material	500.00
75553	with contrast material	500.00
75554	Cardiac magnetic resonance imaging for function, with or without morphology; complete study	500.00
75555	limited study	500.00

VASCULAR PROCEDURES

AORTA AND ARTERIES

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

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

(For intravenous procedures, see 36000-36015, 36400-36425; for intra-arterial procedures, see 36100-36299; for cardiac catheterization procedures, see 93501-93556)

75600	Aortography, thoracic, without serialography, radiological supervision and interpretation	50.00
75605	Aortography, thoracic, by serialography, radiological supervision and interpretation	50.00
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	50.00
75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	75.00

CODE	DESCRIPTION	FEE
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, radiological supervision and interpretation, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	254.00
75650	Angiography, cervicocerebral, catheter,including vessel origin, radiological supervision and interpretation	90.00
75658	Angiography, brachial, retrograde, radiological supervision and interpretation	35.00
75660	Angiography, external carotid, unilateral, selective, radiological supervision and interpretation	90.00
75662	Angiography, external carotid, bilateral, selective, radiological supervision and interpretation	125.00
75665	Angiography, carotid, cerebral, unilateral, radiological supervision and interpretation	90.00
75671	Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation	125.00
75676	Angiography, carotid, cervical, unilateral**,** radiological supervision and interpretation	90.00
75680	Angiography, carotid, cervical, bilateral, radiological supervision and interpretation	125.00
75685	Angiography, vertebral, cervical, and/or intracranial, radiological supervision and interpretation	90.00
75705	Angiography, spinal, selective, radiological supervision and interpretation	130.00
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	35.00
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	56.00
75722	Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation	80.00
75724	Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation	110.00
75726	Angiography, visceral; selective or supraselective, (with or without flush aortogram), radiological supervision and interpretation	50.00
	(For selective angiography, additional visceral vessels studied after basic examination, see 75774)	
75731	Angiography, adrenal, unilateral, selective, radiological supervision and interpretation	80.00
75733	Angiography, adrenal, bilateral, selective, radiological supervision and interpretation	110.00
75736	Angiography, pelvic, selective or supraselective, radiological supervision and interpretation	80.00
75741	Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation	90.00
75743	Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation	120.00

CODE	DESCRIPTION	FEE
75746	Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation	50.00
75756	Angiography, internal mammary, radiological supervision and interpretation	50.00
75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to primary procedure)	25.00
75790	Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation	35.00

VEINS AND LYMPHATICS

(For injection procedures: venous system, see 36000-36015, 36400-36510; lymphatic system, see 38790; percutaneous transluminal angioplasty or transcatheter therapy or biopsy, see 36100-36299; splenoportography, 38200).

75801	Lymphangiography, extremity only, unilateral, radiological supervision and interpretation	50.00
75803	Lymphangiography, extremity only, bilateral, radiological supervision and interpretation	50.00
75805	Lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretation	50.00
75807	Lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretation	50.00
75809	Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation (For procedure, see 49427 or 61070)	40.00
75810	Splenoportography, radiological supervision and interpretation	40.00
75820	Venography, extremity, unilateral, radiological supervision and interpretation	40.00
75822	Venography, extremity, bilateral, radiological supervision and interpretation	64.00
75825	Venography, caval, inferior, with serialography, radiological supervision and interpretation	40.00
75827	Venography, caval, superior, with serialography, radiological supervision and interpretation	40.00
75831	Venography, renal, unilateral, selective, radiological supervision and interpretation	80.00
75833	Venography, renal, bilateral, selective, radiological supervision and interpretation	110.00
75840	Venography, adrenal, unilateral, selective, radiological supervision and interpretation	75.00
75842	Venography, adrenal, bilateral, selective, radiological supervision and interpretation	135.00
75860	Venography, venous sinus (eg, petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation	135.00

CODE	DESCRIPTION	FEE
75870	Venography, superior sagittal sinus, radiological supervision and interpretation	150.00
75872	Venography, epidural, radiological supervision and interpretation	90.00
75880	Venography, orbital, radiological supervision and interpretation	79.00
75885	Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation	90.00
75887	Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation	40.00
75889	Hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation	135.00
75891	Hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation	150.00
75893	Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation	100.00
	(For procedure, see 36500)	

TRANSCATHETER THERAPY AND BIOPSY

(For transluminal angioplasty, open, see 35450-35460)

(For transluminal angioplasty, percutaneous, see 35470-35476)

(For transcatheter therapy and biopsy see 37200-37204)

(For interruption, inferior, vena cava, see 37620)

(For percutaneous cholecystostomy, see 47490)

(For percutaneous transhepatic catheter or stent, see 47510, 47511)

(For change of percutaneous biliary drainage catheter, see 47525)

(For revision/reinsertion of transhepatic T-tube, see 47530)

(For change of nephrostomy or pyelostomy tube, see 50398)

(For change of ureterostomy tube, see 50688)

(For transcatheter occlusion for embolization, see 61624, 61626)

75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	235.00
75896	Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary), radiological supervision and interpretation	170.00
	(For infusion for coronary disease, see 92975, 92977)	
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion	50.00

CODE	DESCRIPTION	FEE
75900	Exchange of a previously placed intravascular catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation	170.00
	(For procedure, use 37209)	
75901	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation	29.00
	(For procedure, use 36595, for venous catheterization, see 36010-36012)	
75902	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation	27.00
	(For procedure, use 36596, for venous catheterization, see 36010, 36012)	
75940	Percutaneous placement of IVC filter, radiological supervision and interpretation	200.00
75945	Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel	56.00
75946	each additional non-coronary vessel (Use 75946 in conjunction with code 75945)	31.00
	(For procedure, see 37250, 37251)	
75952	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation	200.00
	(For implantation of endovascular grafts, see 34800—34808)	
75953	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpreation	50.00
	(For implantation of endovascular extension prosthesis, see 34825, 34826)	
75954	Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, radiological supervision and interpretation	BR
	(For implantation of endovascular graft, see 34900)	

CODE	DESCRIPTION	FEE
75956	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, radiological supervision and interpretation	325.00
75957	not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	278.00
75958	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation	185.00
75959	Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation	163.00
75960	Transcatheter introduction of intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous and/ or open, radiological supervision and interpretation, each vessel	200.00
75961	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation	300.00
	(For procedure, see 37203)	
75962	Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation	100.00
75964	each additional peripheral artery, radiological supervision and interpretation (Use 75964 in conjunction with code 75962)	50.00
75966	Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation	100.00
75968	each additional visceral artery, radiological supervision and interpretation (Use 75968 in conjunction with code 75966)	50.00
	(For percutaneous transluminal coronary angioplasty, see 92982-92984)	
75970	Transcatheter biopsy, radiological supervision and interpretation	100.00
	(For injection procedure only for transcatheter therapy or biopsy,see 36100-36299) (For percutaneous needle biopsy of pancreas, see 48102; of retroperitoneal lymph node or mass, see 49180; for transcatheter renal and uretheral biopsy, see 52007)	
75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation	180.00

CODE	DESCRIPTION	FEE
75980	Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation	115.00
	(For introduction of percutaneous transhepatic catheter or stent for biliary drainage, use 47510, just for change of catheter only, see 47525)	
75982	Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation	45.00
75984	Change of percutaneous tube or drainage catheter with contrast monitoring (eg, gastrointestinal system, genitourinary system, abcess), radiological supervision and interpretation	30.00
	(For percutaneous nephrostolithotomy or pyelostolithotomy, see 50080, 50081)	
75989	Radiological guidance(ie, fluoroscopy, ultrasound or computed tomography), for percutaneous drainage (eg, abcess or specimen collection), with placement of catheter, radiological supervision and interpretation	40.00
	TRANSLUMINAL ATHERECTOMY	
	(For procedure, peripheral artery, see 35481-35485, 35491-35495)	
	(For procedure, renal or visceral artery, see 35480, 35490)	
75992	Transluminal atherectomy, peripheral artery, radiological supervision and interpretation	180.00
75993	each additional peripheral artery, radiological supervision and interpretation (Use 75993 in conjunction with code 75992)	100.00
75994	Transluminal atherectomy, renal, radiological supervision and interpretation	190.00
75995	visceral, radiological supervision and interpretation	190.00
75996	each additional visceral artery, radiological supervision and interpretation (Use 75996 in conjunction with code 75995)	100.00
75998	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	21.00

CODE	DESCRIPTION	FEE

OTHER PROCEDURES

(For arthrography: shoulder, see 73040; elbow, see 73085; wrist, see 73115; hip, see 73525; knee, see 73580; ankle, see 73615)

76000	Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)	10.00
76001	Fluoroscopy, physician time more than one hour, assisting a non-radiologic physician (eg, nephrolithotomy, ERCP, bronchoscopy, transbronchial biopsy)	25.00
76003	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)	25.00
76005	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction	25.00
	(Injection of contrast during fluoroscopic guidance and localization is an inclusive component of codes 62263, 62264, 62270-62273, 62280-62282, 62310-62319)	
	(Fluoroscopic guidance for subarachnoid puncture for diagnostic radiographic myelography is included in supervision and interpretation codes 72240, 72255, 72265, 72270)	
	(For epidural or subarachnoid needle or catheter placement and injection, see codes 62270-62273, 62280-62282, 62310-62319)	
	(For sacroiliac joint arthrography, see 27096, 73542. If formal arthrography is not performed, recorded, and a formal radiographic report is not issued, use 76005 for fluoroscopic guidance for sacroiliac joint injections)	
	(For paravertebral facet joint injection, see 64470-64476. For transforaminal epidural needle placement and injection, see 64479-64484)	
	(For destruction by neurolytic agent, see 64600-64681)	
	(For percutaneous or endoscopic lysis of epidural adhesions, codes 62263, 62264 include fluoroscopic guidance and localization)	
76010	Radiologic examination from nose to rectum for foreign body, single view, child	10.00
76012	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance	25.00
76013	under CT guidance	140.00
	(For procedure, see 22520-22522)	
76020	Bone age studies	15.00

CODE	DESCRIPTION	FEE
76040	Bone length studies (orthoroentgenogram, scanogram)	25.00
76061	Radiologic examination, osseous survey; limited (eg, for metastases)	35.00
76062	complete (axial and appendicular skeleton)	50.00
76065	Radiologic examination osseous survey; infant	35.00
76066	Joint survey, single view, two or more joints (specify)	50.00
76070	Computed tomography, bone mineral density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)	100.00
76071	appendicular skelton (peripheral) (eg, radius, wrist, heel)	52.00
76075	Dual energy x-ray absorptiometry (dxa), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)	100.00
76076	appendicular skeleton (peripheral) (eg, radius, wrist, heel)	52.00
76078	Radiographic absorptiometry (eg, photodensitometry, radiogrammetry),one or more sites	52.00
76080	Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation	15.00
	(For injection of sinus tract, see 20501)	
76086	Mammary ductogram or galactogram, single duct, radiological supervision and interpretation	30.00
76088	Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretation	40.00
	(For injection procedure, mammary ductogram, or galactogram, use 19030; to report as bilateral procedure, use 76088)	
76090	Mammography; unilateral	90.00
76091	bilateral	90.00
76092	Screening mammography, bilateral **(minimum** two view film study of each breast)	90.00
76093	Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral	500.00
76094	bilateral	500.00
76095	Stereotactic localization guidance for breast biopsy or needle placement (for wire localization or for injection), each lesion, radiological supervision and interpretation	105.00
76096	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	70.00
	(For codes 76095 and 76096, see procedure 19000, 19102, 19103) (For injection for sentinel node localization without lymphoscintigraphy, use 38792) (For wire localization, use 19290 or 19291)	
76098	Radiological examination, surgical specimen	25.00
76100	Radiological examination, single plane body section (eg, tomography), other than with urography	30.00

CODE	DESCRIPTION	FEE
76101	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral	45.00
76102	bilateral	57.50
	(For nephrotomography, see 74415)	
76120	Cineradiography/videoradiography, except where specifically included	20.00
76125	Cineradiography/videoradiography, to complement routine examination (List in addition to code for primary procedure)	20.00
76140	Consultation on X-ray examination made elsewhere, written report	15.00
76355	Computed tomography guidance for stereotactic localization	120.00
76360	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	90.00
76362	Computed tomography guidance for, and monitoring of, visceral tissue ablation	90.00
	(For percutaneous radiofrequency ablation, use 47382)	
76370	Computed tomography guidance for placement of radiation therapy fields	75.00
76376	3d rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation	100.00
76377	requiring image postprocessing on an independent workstation	100.00
76380	Computed tomography, limited or localized follow-up study	75.00
76393	Magnetic resonance guidance for needle placement, (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	500.00
76394	Magnetic resonance guidance for, and monitoring of, visceral tissue ablation	500.00
76400	Magnetic resonance (eg, proton) imaging, bone marrow blood supply	500.00
76496	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	BR
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)	BR
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	BR
76499	Unlisted diagnostic radiographic procedure	BR

CODE	DESCRIPTION	FEE

DIAGNOSTIC ULTRASOUND

DEFINITIONS:

A-MODE: Implies a one-dimensional ultrasonic measurement procedure.

M-MODE: Implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.

B-SCAN: Implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.

REAL-TIME SCAN: Implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

HEAD AND NECK

(To report complete A-mode echoencephalography, use 76999)

76506	Echoencephalography, B-scan and/or real time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated	30.00
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative a-scan performed during the same patient encounter	60.00
76511	Ophthalmic ultrasound, diagnostic; quantitative A-scan only	40.00
76512	B-scan (with or without superimposed non-quantitative A-scan)	60.00
76513	anterior segment ultrasound immersion (water bath) B-scan or high resolution biomicroscopy	60.00
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	4.00
76516	Ophthalmic biometry by ultrasound echography, A-scan;	40.00
76519	with intraocular lens power calculation	40.00

(For partial coherence interferometry, use 92136)

76529	Ophthalmic ultrasonic foreign body localization	60.00
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), B-scan and/or real time with image documentation	30.00

CHEST

(To report A-mode echography of the breast, use 76999)

76604	Ultrasound, chest, B-scan (includes mediastinum) and/or real time with image documentation	25.00
76645	Ultrasound, breast(s) (unilateral or bilateral), B-scan and/or real time with image documentation	50.00

CODE	DESCRIPTION	FEE
	ABDOMEN AND RETROPERITONEUM	
76700	Ultrasound, abdominal, B-scan and/or real time with image documentation; complete	60.00
76705	limited (eg, single organ, quadrant, follow-up)	40.00
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete	60.00
76775	limited	60.00
76778	Ultrasound, transplanted kidney, B-scan and/or real time with image documentation, with or without duplex Doppler study	60.00
	SPINAL CANAL	
76800	Ultrasound, spinal canal and contents	60.00
	PELVIS	

OBSTETRICAL

Codes 76801 and 76802 include determination of the number of gestational sacs and fetuses, gestational sac/fetal measurements appropriate for gestation (<14 weeks 0 days), survey of visible fetal and placental anatomic structure, qualitative assessment of amniotic fluid volume/gestational sac shape and examination of the maternal uterus and adnexa.

Codes 76805 and 76810 include determination of number of fetuses and amniotic/chorionic sacs, measurements appropriate for gestational age (> or =14 weeks 0 days), survey of intracranial/spinal/abdominal anatomy, 4 chambered heart, umbilical cord insertion site, placenta location and amniotic fluid assessment and, when visible, examination of maternal adnexa.

Codes 76811 and 76812 include all elements of codes 76805 and 76810 plus detailed anatomic evaluation of the fetal brain/ventricles, face, heart/outflow tracts and chest anatomy, abdominal organ specific anatomy, number/length/architecture of limbs and detailed evaluation of the umbilical cord and placenta and other fetal anatomy as clinically indicated.

Patient record should document the results of the evaluation of each element described above or the reason for non-visualization.

Code 76815 represents a focused "quick look" exam limited to the assessment of one or more of the elements listed in code 76815.

Code 76816 describes an examination designed to reassess fetal size and interval growth or reevaluate one or more anatomic abnormalities of a fetus previously demonstrated on ultrasound, and should be coded once regardless of the number of fetus.

Code 76817 describes a transvaginal obstetric ultrasound performed separately or in addition to one of the transabdominal examinations described above. For transvaginal examinations performed for non-obstetrical purposes, use code 76830.

CODE	DESCRIPTION	FEE

Reimbursement amounts for the Medicaid Obstetrical and Maternal Services Program (MOMS) are noted in parenthesis after the description of each code. For information on the MOMS Program, see Policy Section.

76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach (complete fetal and maternal evaluation); single or first gestation (MOMS 174.00)	55.00
76802	each additional gestation (MOMS 136.00) (List separately in addition to code for primary procedure) (Use 76802 in conjunction with code 76801)	41.00
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach (complete fetal and maternal evaluation); single or first gestation (MOMS 174.00)	55.00
76810	each additional gestation (MOMS 136.00) (List separately in addition to code for primary procedure)	41.00
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach (complete fetal and maternal evaluation); single or first gestation (MOMS 241.00)	72.00
76812	each additional gestation (MOMS 120.00) (List separately in addition to primary procedure) (Use 76812 in conjunction with 76811)	36.00
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses (MOMS 116.00) (Use 76815 only once per exam and not per element) (Use **ONLY** code 76815 to report ultrasound services provided in conjunction with procedure codes 59812-59857. Procedure code 76815 should be billed regardless of the approach used to perform the ultrasound procedure (eg, transvaginal))	25.00
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, reevaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, reevaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus (MOMS 97.00)	25.00
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal (MOMS 190.00) (For non-obstetrical transvaginal ultrasound, use 76830) (If transvaginal examination is done in addition to transabdominal obstetrical ultrasound exam, use 76817 in addition to appropriate transabdominal exam code)	60.00

CODE	DESCRIPTION	FEE
76818	Fetal biophysical profile; with non-stress testing (MOMS 135.00)	35.00
76819	without non-stress testing (MOMS 135.00)	35.00
	(For amniotic fluid index without non-stress test, use 76815)	
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;	25.00
76826	follow-up or repeat study	25.00
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete	25.00
76828	follow-up or repeat study	25.00

NON OBSTETRICAL

76830	Ultrasound, transvaginal	60.00
	(For obstetrical transvaginal ultrasound, use 76817) (If transvaginal examination is done in addition to transabdominal non-obstetrical ultrasound exam, use 76830 in addition to appropriate transabdominal exam code)	
76831	Saline infusion sonohysterography (sis), including color flow doppler, when performed	28.00
	(For introduction of saline or contrast for hysterosonography, use 58340)	
76856	Ultrasound, pelvic (non-obstetric), B-scan and/or real time with image documentation; complete	55.00
76857	limited or follow-up (eg, for follicles)	40.00

GENITALIA

76870	Ultrasound, scrotum and contents	30.00
76872	Ultrasound, transrectal;	60.00
76873	prostate volume study for brachytherapy treatment planning (separate procedure)	60.00

EXTREMITIES

76880	Ultrasound, extremity, non-vascular, B-scan and/or real time with image documentation	30.00
76885	Ultrasound of infant hips, real time with image documentation; dynamic (eg, requiring manipulation)	30.00
76886	limited, static (eg, not requiring physician manipulation)	25.00

VASCULAR STUDIES

(For vascular studies, see 93875-93990)

CODE	DESCRIPTION	FEE

ULTRASONIC GUIDANCE PROCEDURES

(For thoracentesis, see 32000; for pericardiocentesis, see 33010, 33011; for amniocentesis, see 59000; for endomyocardial biopsy, see 93505)

76930	Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation	25.00
76932	Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation	25.00
76936	Ultrasound guided compression repair of arterial pseudo-aneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging)	100.00
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to primary procedure)	55.00
76940	Ultrasound guidance for, and monitoring of, visceral tissue ablation	48.00
76941	Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation	39.00
	(For procedure, see 36460, 59012)	
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	55.00
76945	Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation	32.00
	(For procedure, see 59015)	
76946	Ultrasonic guidance for amniocentesis, imaging supervision and interpretation	20.00
76950	Ultrasonic guidance for placement of radiation therapy fields	35.00
76965	Ultrasonic guidance for interstitial radioelement application	90.00

OTHER PROCEDURES

76975	Gastrointestinal endoscopic ultrasound, supervision and interpretation	30.00
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	30.00
76986	Ultrasonic guidance, intraoperative (Do not report 76986 in addition to 47370-47382)	285.00
	(For ultrasound guidance for open and laparoscopic radiofrequency tissue ablation, use 76940)	
76999	Unlisted ultrasound procedure (eg, diagnostic, interventional)	BR

CODE	DESCRIPTION	FEE

RADIATION ONCOLOGY

Listings for Radiation Oncology provide for teletherapy and brachytherapy to include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services, and clinical treatment management procedures. They include normal follow-up care during course of treatment and for three months following its completion.

For treatment by injectable or ingestible isotopes, see subsection **Nuclear Medicine**.

CONSULTATION: CLINICAL MANAGEMENT

Preliminary consultation, evaluation of patient prior to decision to treat, or full medical care (in addition to treatment management) when provided by the therapeutic radiologist may be identified by the appropriate procedure codes from Evaluation and Management, Medicine or Surgery sections.

CLINICAL TREATMENT PLANNING (EXTERNAL AND INTERNAL SOURCES)

The clinical treatment planning process is a complex service including interpretation of special testing, tumor localization, treatment volume determination, treatment time/dosage determination, choice of treatment modality, determination of number and size of treatment ports, selection of appropriate treatment devices, and other procedures.

DEFINITIONS:

SIMPLE - planning requiring single treatment area of interest encompassed in a single port or simple parallel opposed ports with simple or no blocking.

INTERMEDIATE - planning requiring three or more converging ports, two separate treatment areas, multiple blocks, or special time dose constraints.

COMPLEX - planning requiring highly complex blocking, custom shielding blocks, tangential ports, special wedges or compensators, three or more separate treatment areas, rotational or special beam considerations, combination of therapeutic modalities.

77261	Therapeutic radiology treatment planning; simple	154.00
77262	intermediate	230.00
77263	complex	311.80

SIMPLE - simulation of a single treatment area with either a single port or parallel opposed ports. Simple or no blocking.

INTERMEDIATE - simulation of three or more converging ports, two separate treatment areas, multiple blocks.

COMPLEX - simulation of tangential portals, three or more treatment areas, rotation or arc therapy, complex blocking, custom shielding blocks, brachytherapy source verification, hyperthermia probe verification, any use of contrast materials.

CODE	DESCRIPTION	FEE

Three-dimensional computer-generated three dimensional reconstruction of tumor volume and surrounding critical normal tissue structures from direct CT scans and/or MRI data in preparation for non-coplanar or coplanar therapy. The stimulation utilizes documented three-dimensional beam's eye view volume-dose displays of multiple or moving beams. Documentation with three-dimensional volume reconstruction and dose distribution is required.

Simulation may be carried out on a dedicated simulator, a radiation therapy treatment unit, or diagnostic x-ray machine.

77280	Therapeutic radiology simulation-aided field setting; simple	47.40
77285	intermediate	73.80
77290	complex	103.60
77295	three-dimensional	103.60
77299	Unlisted procedure, therapeutic radiology clinical treatment planning	BR

MEDICAL RADIATION PHYSICS, DOSIMETRY, TREATMENT DEVICES AND SPECIAL SERVICES

77300	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician	31.00
77305	Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)	45.20
77310	intermediate (three or more treatment ports directed to a single area of interest)	63.40
77315	complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)	89.60
77321	Special teletherapy port plan, particles, hemi-body, total body	70.00
	(Only one teletherapy isodose plan may be reported for a given course of therapy to a specific treatment area.)	
77326	Brachytherapy isodose plan; simple (calculation made from single plane, one to four sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources) (For definition of sources/ribbon, see Clinical Brachytherapy section)	58.20
77327	intermediate (multiplane dosage calculations, application involving five to ten sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)	76.00
77328	complex (multiplane isodose plan, volume implant calculations, over ten sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)	101.00
77331	Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician	66.80

CODE	DESCRIPTION	FEE
77332	Treatment devices, design and construction; simple (simple block, simple bolus)	34.80
77333	intermediate (multiple blocks, stents, bite blocks, special bolus)	58.40
77334	complex (irregular blocks, special shields, compensators, wedges, molds or casts)	79.20
77336	Continuing medical radiation physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy	41.80
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	BR

RADIATION TREATMENT DELIVERY

Radiation treatment delivery (77401-77416) recognizes the technical component and the various energy levels.

77401	Radiation treatment delivery, superficial and/or ortho voltage	53.40
77402	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV	48.60
77403	6-10 MeV	48.60
77404	11-19 MeV	48.60
77406	20 MeV or greater	48.60
77407	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; up to 5 MeV	57.50
77408	6-10 MeV	57.50
77409	11-19 MeV	57.50
77411	20 MeV or greater	57.50
77412	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV	63.70
77413	6-10 MeV	63.70
77414	11-19 MeV	63.70
77416	20 MeV or greater	63.70
77417	Therapeutic radiology port film(s)	21.60

RADIATION TREATMENT MANAGEMENT

Radiation treatment management is reported in units of five fractions or treatment sessions, regardless of the actual time period in which the services are furnished. The services need not be furnished on consecutive days. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days. Code 77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately.

CODE	DESCRIPTION	FEE

The professional services furnished during treatment management typically consists of:Review of port films;

- Review of dosimetry, dose delivery, and treatment parameters;
- Review of patient treatment set-up;
- Examination of patient for medical evaluation and management (eg, assessment of the patient's response to treatment, coordination of care and treatment, review of imaging and/or lab results).

77427	Radiation treatment management, five treatments (Weekly clinical management is based on five fractions delivered comprising one week regardless of the time interval separating the delivery of treatments)	145.80
77431	Radiation therapy management with complete course of therapy consisting of one or two fractions only (77431 is not to be used to fill in the last week of a long course of therapy)	75.80
77432	Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session)	100.00
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intra-operative cone irradiation) (77470 assumes that the procedure be performed one or more times during the course of therapy, in addition to daily or weekly patient management)	77.40
77499	Unlisted procedure, therapeutic radiology treatment management	BR

HYPERTHERMIA

Hyperthermia treatments as listed in this section include external (superficial and deep), interstitial, and intracavitary. Radiation therapy when given concurrently is listed separately.

Hyperthermia is used only as an adjunct to radiation therapy or chemotherapy. It may be induced by a variety of sources, (eg, microwave, ultrasound, low energy radio-frequency conduction, or by probes).

The listed treatments include management during the course of therapy and follow-up care for three months after completion. Preliminary consultation is not included (see Evaluation and Management 99241-99255). Physics planning and interstitial insertion of temperature sensors, and use of external or interstitial heat generating sources are included.

The following descriptors are included in the treatment schedule:

77600	Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)	BR
77605	deep (ie, heating to depths greater than 4 cm)	BR
77610	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators	BR
77615	more than 5 interstitial applicators	BR

CODE	DESCRIPTION	FEE

CLINICAL INTRACAVITARY HYPERTHERMIA

77620	Hyperthermia generated by intracavitary probe(s)	BR

CLINICAL BRACHYTHERAPY

Clinical brachytherapy requires the use of either natural or man-made radioelements applied into or around a treatment field of interest. The supervision of radioelements and dose interpretation are performed solely by the therapeutic radiologist. When a procedure requires the service of a surgeon, see appropriate codes from the Surgery Section.

Services 77750-77799 include admission to the hospital and daily visits.

For insertion of ovoids and tandems, use 57155.

For insertion of Heyman capsules, use 58346.

DEFINITIONS:

(Sources refer to intracavitary placement or permanent interstitial placement; ribbons refer to temporary interstitial placement.)

SIMPLE - application with one to four sources/ribbons

INTERMEDIATE - application with five to ten sources/ribbons

COMPLEX - application with greater than ten sources/ribbons

77750	Infusion or instillation of radioelement solution (includes three months follow-up care)	209.60
77761	Intracavitary radiation source application; simple	316.60
77762	intermediate	371.20
77763	complex	427.60
77776	Interstitial radiation source application; simple	390.60
77777	intermediate	453.40
77778	complex	519.60
77781	Remote afterloading high intensity brachytherapy; 1-4 source positions or catheters	619.80
77782	5-8 source positions or catheters	659.80
77783	9-12 source positions or catheters	719.40
77784	over 12 source positions or catheters	809.10
77789	Surface application of radiation source	85.00
77799	Unlisted procedure, clinical brachytherapy	BR

CODE	DESCRIPTION	FEE

NUCLEAR MEDICINE

The services listed do not include the provision of radium or other radioelements. Those materials supplied by the provider should be billed separately and identified by the specific code describing the diagnostic radiopharmaceutical(s) and/or the therapeutic radiopharmaceutical(s) which are listed under ***Radiopharmaceutical Imaging Agents*** .

DIAGNOSTIC

ENDOCRINE SYSTEM

78000	Thyroid uptake; single determination	15.00
78001	multiple determinations	20.00
78003	stimulation, suppression or discharge (not including initial uptake studies)	25.00
78006	Thyroid imaging, with uptake; single determination	40.00
78007	multiple determinations	37.00
78010	Thyroid imaging; only	25.00
78011	with vascular flow	35.00
78015	Thyroid carcinoma metastases imaging; limited area (eg, neck and chest only)	45.00
78016	with additional studies (eg, urinary recovery)	60.00
78018	whole body	90.00
78020	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)	40.00
78070	Parathyroid imaging	60.00
78075	Adrenal imaging, cortex and/or medulla	60.00
78099	Unlisted endocrine procedure, diagnostic nuclear medicine	BR

HEMATOPOIETIC, RETICULOENDOTHELIAL AND LYMPHATIC SYSTEM

78102	Bone marrow imaging; limited area	45.00
78103	multiple areas	45.00
78104	whole body	60.00
78110	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling	20.00
78111	multiple samplings	32.00
78120	Red cell volume determination (separate procedure); single sampling	30.00
78121	multiple samplings	48.00
78122	Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)	42.00
78130	Red cell survival study;	50.00
78135	differential organ/tissue kinetics, eg, splenic and/or hepatic sequestration	75.00

CODE	DESCRIPTION	FEE
78185	Spleen imaging only, with or without vascular flow	70.00
	(If combined with liver study, use procedures 78215, 78216)	
78190	Kinetics, study of platelet survival, with or without differential organ/tissue localization	BR
78191	Platelet survival study	BR
78195	Lymphatics and lymph nodes imaging	40.00
	(For sentinel node identification without scintigraphy imaging, use 38792) (For sentinel node excision, see 38500-38542)	
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	BR

GASTROINTESTINAL SYSTEM

78201	Liver imaging; static only	40.00
78202	with vascular flow	50.00
78205	Liver imaging (SPECT);	115.00
78206	with vascular flow	125.00
78215	Liver and spleen imaging; static only	60.00
78216	with vascular flow	70.00
78220	Liver function study with hepatobiliary agents, with serial images	30.00
78223	Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function	30.00
78230	Salivary gland imaging;	35.00
78231	with serial images	35.00
78232	Salivary gland function study	35.00
78258	Esophageal motility	40.00
78261	Gastric mucosa imaging	40.00
78262	Gastroesophageal reflux study	40.00
78264	Gastric emptying study	40.00
78270	Vitamin B-12 absorption study (eg, Schilling test); without intrinsic factor	25.00
78271	with intrinsic factor	30.00
78272	Vitamin B-12 absorption studies combined, with and without intrinsic factor	50.00
78278	Acute gastrointestinal blood loss imaging	40.00
78290	Intestine imaging (eg, ectopic gastric mucosa, Meckel's localization, volvulus)	40.00
78291	Peritoneal-venous shunt patency test (eg, for LeVeen, Denver shunt)	40.00
	(For injection procedure, use 49427)	
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine	BR

CODE	DESCRIPTION	FEE

MUSCULOSKELETAL SYSTEM

Bone and joint imaging can be used in the diagnosis of a variety of infectious inflammatory diseases (eg, osteomyelitis), as well as for localization of primary and/or metastatic neoplasms.

78300	Bone and/or joint imaging; limited area	60.00
78305	multiple areas	60.00
78306	whole body	60.00
78315	three phase study	80.00
78320	tomographic (SPECT)	115.00
78350	Bone density (bone mineral content) study, one or more sites; single photon absorptiometry	40.00
78351	dual photon absorptiometry	64.00
	(For radiolgraphic bone density (photodensitometry), use 76078)	
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	BR

CARDIOVASCULAR SYSTEM

Myocardial perfusion and cardiac blood pool imaging studies may be performed at rest and/or during stress. When performed during exercise and/or pharmacologic stress, the appropriate stress testing code from the 93015-93018 series should be reported in addition to code(s) 78460-78465, 78472, 78473, 78478, 78480, 78481, 78483, 78491 and 78492.

78414	Determination of central c-v hemodynamics (non-imaging) (eg, ejection fraction with probe technique) with or without pharmacologic intervention or exercise, single or multiple determinations	30.00
78445	Non-cardiac vascular flow imaging (ie, angiography, venography)	30.00
78456	Acute venous thrombosis imaging, peptide	60.00
78457	Venous thrombosis imaging, venogram; unilateral	30.00
78458	bilateral	48.00
78460	Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification	60.00
78461	multiple studies, (planar) at rest and/or stress (exercise and/or pharmacologic), and redistribution and/or rest injection, with or without quantification	186.00
78464	tomographic (spect), single study (including attenuation correction when performed), at rest or stress (exercise and/ or pharmacologic), with or without quantification	186.00
78465	tomographic (spect), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification	186.00
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative	60.00
78468	with ejection fraction by first pass technique	60.00
78469	tomographic SPECT with or without quantification	115.00

CODE	DESCRIPTION	FEE
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing	150.00
	(For assessment of cardiac function by first pass technique, use 78496)	
78473	multiple studies, wall motion study plus ejection pharmacologic), with or without additional quantification	150.00
78478	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to primary procedure) (Use only for codes 78460 - 78465)	30.00
78480	Myocardial perfusion study with ejection fraction (List separately in addition to primary procedure) (Use only for codes 78460-78465)	30.00
78481	Cardiac blood pool imaging, (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	150.00
78483	multiple studies, at rest and with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	240.00
	(For cerebral blood flow study, see 78615)	
78491	Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress	1,850.00
78492	multiple studies at rest and/or stress	1,850.00
78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing	186.00
78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (Use 78496 in conjunction with code 78472)	166.00
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine	BR
RESPIRATORY SYSTEM		
78580	Pulmonary perfusion imaging; particulate	60.00
78584	Pulmonary perfusion imaging, particulate, with ventilation; single breath	116.00
78585	rebreathing and washout, with or without single breath	116.00
78586	Pulmonary ventilation imaging, aerosol; single projection	80.00
78587	multiple projections (eg, anterior, posterior, lateral views)	80.00
78588	Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, one or multiple projections	116.00
78591	Pulmonary ventilation imaging, gaseous, single breath, single projection	80.00

CODE	DESCRIPTION	FEE
78593	Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection	80.00
78594	multiple projections (eg, anterior, posterior, lateral views)	80.00
78596	Pulmonary quantitative differential function (ventilation/perfusion) study	120.00
78599	Unlisted respiratory procedure; diagnostic nuclear medicine	BR

NERVOUS SYSTEM

(For injection procedures for codes 78630-78650, see 61000-61070; 62270-62319)

78600	Brain imaging, limited procedure; static	60.00
78601	with vascular flow	70.00
78605	Brain imaging, complete study; static	60.00
78606	with vascular flow	70.00
78607	tomographic (SPECT)	115.00
78610	Brain imaging, vascular flow only	40.00
78615	Cerebral vascular flow	80.00
78630	Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography	75.00
78635	ventriculography	75.00
78645	shunt evaluation	75.00
78647	tomographic (SPECT)	115.00
78650	Cerebrospinal fluid leakage detection and localization	75.00
78660	Radiopharmaceutical dacryocystography	20.00
78699	Unlisted nervous system procedure, diagnostic nuclear medicine	BR

GENITOURINARY SYSTEM

(For associated introduction of radioactive substance: cystotomy or cystostomy, see 51020; cystourethroscopy, see 52250;)

78700	Kidney imaging; static only	40.00
78701	with vascular flow	50.00
78704	with function study (ie, imaging renogram)	85.00
78707	Kidney imaging with vascular flow and function; single study without pharmacological intervention	95.00
78708	single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)	100.00
78709	multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)	104.00
78710	Kidney imaging, tomographic (SPECT)	115.00
78715	Kidney vascular flow only	40.00
78725	Kidney function study, non-imaging radioisotopic study	25.00
78730	Urinary bladder residual study	25.00
78740	Ureteral reflux study (radiopharmaceutical voiding cystogram)	85.00

(For catheterization, see 51701, 51702, 51703)

78760	Testicular imaging;	40.00
78761	with vascular flow	50.00

CODE	DESCRIPTION	FEE
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine	BR

MISCELLANEOUS PROCEDURES

(For imaging bone infectious or inflammatory disease, see 78300, 78305, 78306)

(For radiophosphorus tumor identification, ocular, see 78800)

78800	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area	60.00
78801	multiple areas	60.00
78802	whole body, single day imaging	60.00
78803	tomographic (SPECT)	115.00
78804	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging	60.00
78805	Radiopharmaceutical localization of inflammatory process; limited area	60.00
78806	whole body	60.00
78807	tomograhic (SPECT)	115.00
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine	BR

THERAPEUTIC

79005	Radiopharmaceutical therapy, by oral administration	30.00
79101	Radiopharmaceutical therapy, by intravenous administration	30.00
79200	Radiopharmaceutical therapy, by intracavitary administration	45.00
79300	Radiopharmaceutical therapy, by interstitial radioactive colloid administration	150.00
79403	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion	30.00
79440	Radiopharmaceutical therapy, by intra-articular administration	30.00
79445	Radiopharmaceutical therapy, by intra-arterial particulate administration	BR
79999	Unlisted radiopharmaceutical therapeutic procedure	BR

RADIOPHARMACEUTICAL IMAGING AGENTS

A4641	Radiopharmaceutical, diagnostic, not otherwise classified	BR
A4642	Indium in-111 satumomab pendetide, diagnostic, per study dose up to 6 millicuries	BR
A9500	Technetium tc-99m sestamibi, diagnostic, per study dose, up to 40 millicuries	BR
A9502	Technetium tc-99m tetrofosmin, diagnostic, per study dose, up to 40 millicuries	BR
A9503	Technetium tc-99m medronate, diagnostic, per study dose, up to 30 millicuries	BR
A9504	Technetium tc-99m apcitide, diagnostic, per study dose, up to 20 millicuries	BR
A9505	Thallium tl-201 thallous chloride, diagnostic, per millicurie	BR

CODE	DESCRIPTION	FEE
A9507	Indium in-111 capromab pendetide, diagnostic, per study dose, up to 10 millicuries	BR
A9508	Iodine i-131 iobenguane sulfate, diagnostic, per 0.5 millicurie	BR
A9510	Technetium tc-99m disofenin, diagnostic, per study dose, up to 15 millicuries	BR
A9512	Technetium tc-99m pertechnetate, diagnostic, per millicurie	BR
A9516	Iodine i-123 sodium iodide capsule(s), diagnostic, per 100 microcuries	BR
A9517	Iodine i-131 sodium iodide capsule(s), therapeutic, per millicurie	BR
A9521	Technetium tc-99m exametazime, diagnostic, per study dose, up to 25 millicuries	BR
A9524	Iodine i-131 iodinated serum albumin, diagnostic, per 5 microcuries	BR
A9526	Nitrogen n-13 ammonia, diagnostic, per study dose, up to 40 millicuries	BR
A9528	Iodine i-131 sodium iodide capsule(s), diagnostic, per millicurie	BR
A9529	Iodine i-131 sodium iodide solution, diagnostic, per millicurie	BR
A9530	Iodine i-131 sodium iodide solution, therapeutic, per millicurie	BR
A9531	Iodine i-131 sodium iodide, diagnostic, per microcurie (up to 100 microcuries)	BR
A9532	Iodine i-125 serum albumin, diagnostic, per 5 microcuries	BR
A9535	Methylene blue, 1 ml	BR
A9536	Technetium tc-99m depreotide, diagnostic, per study dose, up to 35 millicuries	BR
A9537	Technetium tc-99m mebrofenin, diagnostic, per study dose, up to 15 millicuries	BR
A9538	Technetium tc-99m pyrophosphate, diagnostic, per study dose, up to 25 millicuries	BR
A9539	Technetium tc-99m pentetate, diagnostic, per study dose, up to 25 millicuries	BR
A9540	Technetium tc-99m macroaggregated albumin, diagnostic, per study dose, up to 10 millicuries	BR
A9541	Technetium tc-99m sulfur colloid, diagnostic, per study dose, up to 20 millicuries	BR
A9542	Indium in-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries	BR
A9543	Yttrium y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	BR
A9544	Iodine i-131 tositumomab, diagnostic, per study dose	BR
A9545	Iodine i-131 tositumomab, therapeutic, per treatment dose	BR
A9546	Cobalt co-57/58, cyanocobalamin, diagnostic, per study dose, up to 1 microcurie	BR
A9547	Indium in-111 oxyquinoline, diagnostic, per 0.5 millicurie	BR
A9548	Indium in-111 pentetate, diagnostic, per 0.5 millicurie	BR
A9549	Technetium tc-99m arcitumomab, diagnostic, per study dose, up to 25 millicuries	BR
A9550	Technetium tc-99m sodium gluceptate, diagnostic, per study dose, up to 25 millicurie	BR

CODE	DESCRIPTION	FEE
A9551	Technetium tc-99m succimer, diagnostic, per study dose, up to 10 millicuries	BR
A9553	Chromium cr-51 sodium chromate, diagnostic, per study dose, up to 250 microcuries	BR
A9554	Iodine i-125 sodium iothalamate, diagnostic, per study dose, up to 10 microcuries	BR
A9557	Technetium tc-99m bicisate, diagnostic, per study dose, up to 25 millicuries	BR
A9558	Xenon xe-133 gas, diagnostic, per 10 millicuries	BR
A9559	Cobalt co-57 cyanocobalamin, oral, diagnostic, per study dose, up to 1 microcurie	BR
A9560	Technetium tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 millicuries	BR
A9561	Technetium tc-99m oxidronate, diagnostic, per study dose, up to 30 millicuries	BR
A9562	Technetium tc-99m mertiatide, diagnostic, per study dose, up to 15 millicuries	BR
A9563	Sodium phosphate p-32, therapeutic, per millicurie	BR
A9564	Chromic phosphate p-32 suspension, therapeutic, per millicurie	BR
A9565	Indium in-111 pentetreotide, diagnostic, per millicurie	BR
A9566	Technetium tc-99m fanolesomab, diagnostic, per study dose, up to 25 millicuries	BR
A9567	Technetium tc-99m pentetate, diagnostic, aerosol, per study dose, up to 75 millicuries	BR
A9600	Strontium sr-89 chloride, therapeutic, per millicurie	BR
A9605	Samarium sm-153 lexidronamm, therapeutic, per 50 millicuries	BR
A9699	Radiopharmaceutical, therapeutic, not otherwise classified	BR
C2637	Brachytherapy source, ytterbium-169, per source	BR

CODE	DESCRIPTION	FEE

POSITRON EMISSION TOMOGRAPHY (PET) SERVICES

Maximum reimbursement amounts are for the complete procedure (professional and technical/administrative components) including the tracer. To receive reimbursement for only the professional component, see modifier -26 Professional Component.

78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation (**Report Required**)	1,634.00
78491	Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress (**Report Required**)	1,634.00
78492	multiple studies at rest and/or stress (**Report Required**)	1,634.00
78608	Brain imaging, positron emission tomography (PET), metabolic evaluation (**Report Required**)	1,634.00
78609	perfusion evaluation (**Report Required**)	1,634.00
78811	Tumor imaging, positron emission tomography (PET), limited area (eg, chest, head/neck) (**Report Required**)	1,634.00
78812	skull base to mid-thigh (**Report Required**)	1,634.00
78813	whole body (**Report Required**)	1,634.00
78814	with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (eg, chest, head/neck) (**Report Required**)	1,718.00
78815	with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid-thigh (**Report Required**)	1,970.00
78816	with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body (**Report Required**)	2,222.00

APPENDIX A

Physician Specialty	Specialty Code
Aerospace Medicine	185
Allergy and Immunology	010
Anesthesiology	020
Cardiovascular Disease	062
Child Neurology	193
Child Psychiatry	191
Colon and Rectal Surgery	030
Dermatology	040
Diagnostic Radiology	201
Diagnostic Radiology with Special Competence in Nuclear Radiology	202
Emergency Medicine	250
Endocrinology and Metabolism	063
Family Practice	050
Gastroenterology	064
General Preventive Medicine	182
General Surgery	210
Gynecologic Oncology	242
Hematology	065
HIV Enhanced Fees for Physicians	249
Infectious Disease	066
Internal Medicine	060
Maternal and Fetal Medicine	092
Medical Oncology	241
Neonatal – Perinatal Medicine	155
Nephrology	067
Neurological Surgery	070
Neurology	194
Nuclear Medicine	080
Obstetrics and Gynecology	089
Occupational Medicine	183

Ophthalmology	100
Orthopedic Surgery	110
Otolaryngology	120
Pediatric Cardiology	151
Pediatric Critical Care	161
Pediatric Endocrinology	156
Pediatric Gastroenterology	163
Pediatric Hematology – Oncology	152
Pediatric Nephrology	154
Pediatric Pulmonology	157
Pediatric Surgery	153
Pediatrics	150
Physical Medicine and Rehabilitation	160
Plastic Surgery	170
Preferred Physician and Childrens Program (PPAC)	158
Psychiatry	192
Psychiatry and Neurology	195
Public Health	184
Pulmonary Disease	068
Radiology	200
Reproductive Endocrinology	093
Rheumatology	069
Therapeutic Radiology	205
Thoracic Surgery	220
Urology	230