NEW YORK STATE
MEDICAID PROGRAM

PHYSICIAN

FEE SCHEDULE

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H. RADIOLOGY

I.

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 following worksheet specifies the questions asked on the voice interactive telephone system and must be maintained in the patient’s clinical record:

NEW YORK STATE MEDICAID PROGRAM
ENTERAL FORMULA PRIOR AUTHORIZATION
PRESCRIBER WORKSHEET- REVISED 4/05

To facilitate the process, be prepared to answer these questions when you call the voice interactive Enteral Prior Authorization Call Line at **1-866-211-1736**. Documentation must be maintained in the patient's medical record.

PRESCRIBER IDENTIFIER Ordering Prescriber Medicaid ID # NYS Physician/PA/Resident NYS Nurse Practitioner/Midwife NYS Dentist Out of State Prescriber License	Complete one of the following prescriber identifiers: MMIS ID Number __ __ __ __ __ __ __ __ **0 0** __ __ __ __ __ __ **F** __ __ __ __ __ __ **0 0 0** __ __ __ __ __ __ __ __ __ __ __ __ __ (state abbreviation in first two spaces)
1. Recipient CIN (Client ID number is 2 alpha/5 numeric/1 alpha)	__ __ __ __ __ __ __ __
2. Recipient Date of Birth (MM/DD/YYYY)	__ __ **/** __ __ **/** __ __ __ __
3. Prescriber telephone number (where you can be reached)	**(**__ __ __**)** __ __ __ **-** __ __ __ __
4. Mode of administration	1 = Tube 2= Oral
5. If less than one year of age, does the patient require an added rice formula?	1 = Yes 2 = No
6. Are you prescribing more than one enteral formula?	1 = Yes 2 = No
7. Number of enteral formula calories prescribed per day.	__ __ __ __
8. Number of refills (up to 5)	___

Answer the following questions for oral administration only:

9. Is the enteral formula prescribed for an inborn metabolic disease or an infant formula for lactose intolerance, severe food allergy or gastroesophogeal reflux disease not responding to added rice formula?	1 = Yes 2 = No
10. Patient height in inches	__ __ inches
11. Patient weight in pounds	__ __ __ lbs

Coverage criteria for enteral formula explained on telephone system

12. Does this patient have a medical condition that prevents him/her from consuming normal table, and softened, mashed, pureed, or blenderized foods?	1 = Yes 2 = No
13. Have alternatives such as dietary changes, instant breakfast drinks, rice cereal, etc., been tried but were not successful?	1 = Yes 2 = No
14. Has the adult patient had a significant unintentional weight loss (>5%) over the past two months or the pediatric patient had no weight gain in six months?	1 = Yes 2 = No
15. Is there objective medical evidence in the medical record to support the need for enteral nutrition (e.g., malnutrition documented by serum protein levels, albumin levels or hemoglobin, changes in skin or bones, physiological disorders resulting from surgery)?	1 = Yes 2 = No

Record the 11-digit prior authorization number here (for your records) and on top of the patient's enteral formula order/prescription.	__ __ __ __ __ __ __ __ __ __ __

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. The second (bilateral) procedure is identified by adding 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.)

-AA Anesthesia Services Performed 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 99116, 99190, 99192 and Anesthesia Section, Rule #3. For conscious sedation, see 99141, 99142.

-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 Family Planning Services: 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 $17.65, 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. (For complete procedure descriptions, see page 7-22; for fees, see page 7-60)

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.**

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. The second (bilateral) procedure is identified by adding 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 CODES

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 "1". The Maximum Fee-NYS for Office Evaluation and Management services is $30.00. For services rendered in a Hospital Outpatient setting report place of service "7". For the Maximum Fee-NYS for codes 99201-99205 and 99211-99215 in a Hospital Outpatient setting see Appendix A for the appropriate Physician Specialty code(s) and page references.

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.

(For Medicine Section, General Information and Rules, see page 7-9; for fees, see page 7-60).

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.

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 and Confirmatory Outpatient Consultation codes (99251-99275).

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. For more information, see page 7-22.

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.

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 four subcategories of consultations: office, initial consultation (other than office), follow-up consultation (other than office), and confirmatory. 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.

FOLLOW-UP INPATIENT CONSULTATIONS ESTABLISHED PATIENT

Follow-up consultations are visits to complete the initial consultation OR subsequent consultative visits requested by the attending practitioner or other appropriate source. A follow-up consultation includes monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status.

If the physician consultant has initiated treatment at the initial consultation, and participates thereafter in the patient's management, the appropriate code for subsequent care or established patient should be used.

The following codes are used to report follow-up consultations provided to hospital inpatients or nursing facility residents only. For consultative services provided in other settings, the codes for office or other outpatient consultations should be reported (99241-99245).

99261 Follow-up inpatient consultation (other than office) for 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 or of low complexity.

Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's hospital floor or unit.

For example:

Follow-up inpatient consultation with 35-year-old female with pulmonary embolism, post-op cesarean section, now stable, for assessment of response to anticoagulation and recommended adjustment of heparin dose.

Follow-up inpatient consultation with 67-year-old female, established patient for review of diagnostic studies ordered at time of first contact.

Follow-up consultation for a 74-year-old male whose postoperative facial paralysis after a cholecystectomy is now resolving.

99262 Follow-up inpatient consultation (other than office) for 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 moderate complexity.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

For example:

Follow-up inpatient consultation with 72-year-old female, established patient with bullous pemphigoid on combined oral therapy steroids and immunosuppressive to evaluate progress of cutaneous care orders and adjustment of oral/parenteral therapy dosages.

Follow-up inpatient consultation with 51-year-old male, for evaluation and determination of the etiology of post-operative hyponatremia following TURP.

Follow-up hospital consultation for a 71-year-old male who has developed a maculopapular skin rash while on antibiotics that you recommended for an uncomplicated pneumonia.

Follow-up hospital consultation for reevaluation of a stroke patient, and development of plan for initial rehabilitation services.

Follow-up inpatient consultation with 68-year-old, incapacitated male, with spinal stenosis and failure to respond to bedrest, analgesics, and PT.

Follow-up inpatient consultations with 45-year-old male, established patient for discussion of CT scan which demonstrates a cavernous hemangioma.

99263 Follow-up inpatient consultation (other than office) for 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 high complexity.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

For example:

Follow-up inpatient consultation with 72-year-old male established patient admitted for management of alcohol withdrawal, now confused and febrile.

Follow-up inpatient consultation with 58-year-old diabetic female, with bacterial endocarditis, continued fever after 2 weeks of intravenous antibiotic therapy, and new onset ventricular ectopia.

Follow-up inpatient consultation for an HIV positive patient with an increasing fever following ten days of antibiotic therapy for pneumocystis carinii pneumonia.

CONFIRMATORY CONSULTATIONS NEW OR ESTABLISHED PATIENT

The following codes are used to report the evaluation and management services provided to patients when the consulting physician is aware of the confirmatory nature of the opinion sought (e.g., when a second/third opinion is requested or required on the necessity or appropriateness of a previously recommended medical treatment or surgical procedure). Confirmatory consultations may be provided in any setting.

A physician consultant providing a confirmatory consultation is expected to provide an opinion and/or advice only. Any services subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care.

Typical times and examples have not yet been established for this subcategory of services. When reporting procedure codes 99271-99275 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.

99271 Confirmatory 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.

99272 Confirmatory 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.

99273 Confirmatory 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.

99274 Confirmatory 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.

99275 Confirmatory 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.

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 **(face-to-face)**delivery by a physician(s) of medical care for a critically ill or critically injured patient. Critical care is the care of unstable critically ill or unstable critically injured patients who require constant physician attendance. 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 vital organ 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 on 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 hands on critical care services during the hospital stay. 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 through the 28th postnatal day. The reporting of pediatric and neonatal critical care services is not based on time or the type of unit (e.g., pediatric or neonatal critical care unit). For additional instructions on reporting these services, see the Neonatal and Pediatric Critical Care 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.

The following services are included in reporting critical care when performed during the critical period by the physician providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry, blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data); gastic intubation (43752, 91105); temporary transcutaneous pacing (92953); ventilator management; and, vascular access procedures (36000, 36540, 36600). Any services performed which are not listed above should be reported separately and should not be included in the time reported as critical care time. **(Report required)**

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, that time spent at the immediate bedside.

The critical care codes are used to report the total duration of time spent by a physician providing constant attention (**face-to-face**) to an unstable critically ill or unstable injured patient. Code 99291 is used to report the first hour of critical care on a given day. It should be used only once per day even if the time spent by the physician is not continuous on that day. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code. Code 99292 is used to report each additional 30 minutes beyond the first hour. It also may be used to report the final 15-30 minutes of critical care on a given date. Critical care of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. **For example**, if 1 hour of critical care is provided at 10 AM and 2 hours provided from 3 PM to 5 PM, then report the total of three hours on a single day.

99291 Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician **(Report required);** 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 Intensive Low Birth Weight 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 Intensive Low Birth Weight 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 (90780, 90781), 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.

INTENSIVE (NON-CRITICAL) LOW BIRTH WEIGHT SERIVCES

Codes 99298-99299 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) or very low birth weight (VLBW) infant who no longer meets the definition of critically ill. They represent subsequent day(s) of care and may be reported only once per day, per patient. Low birth weight services are reported for those neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and interventions only available in an intensive care setting. The level and frequency of services required for the LBW and the VLBW infant exceed those available in less intensive hospital areas or medical floors. Codes 99298-99299 are global 24-hour codes with the same services bundled as outlined under codes 99293-99296.

For additional instructions, see descriptions listed for 99298-99299.

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 no longer critically ill 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 no longer critically ill 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)).

COMPREHENSIVE NURSING FACILITY ASSESSMENTS - NEW OR ESTABLISHED PATIENT

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

99301 Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three key components: a detailed interval history, a comprehensive examination, and medical decision making that is straightforward or of low complexity.

Usually, the patient is stable, recovering or improving. The review and affirmation of the medical plan of care is required.

Practitioners typically spend 30 minutes at the bedside and on the patient's facility floor or unit.

99302 Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components: a detailed interval history, a comprehensive examination, and medical decision making of moderate to high complexity.

Usually, the patient has developed a significant complication or a significant new problem and has had a major permanent change in status. The creation of a new medical plan of care is required.

Practitioners typically spend 40 minutes at the bedside and on the patient's facility floor or unit.

99303 Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate to high complexity. The creation of a medical plan of care is required.

Practitioners typically spend 50 minutes at the bedside and on the patient's facility floor or unit.

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.

99311 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 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 facility floor or unit.

99312 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: 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 facility floor or unit.

99313 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 to high complexity.

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

Practitioners typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

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

99321 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 or of low complexity.

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

99322 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 moderate complexity.

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

99323 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 high complexity.

Usually, the presenting problem(s) are of high complexity.

ESTABLISHED PATIENT

99331 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 or of low complexity.

Usually, the patient is stable, recovering or improving.

99332 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 moderate complexity.

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

99333 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 high complexity.

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

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.

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, 99301-99350)

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, 99261-99263)

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

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 positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output.	

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.

EVALUATION AND MANAGEMENT SERVICES

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

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

(For Medicine Section, General Information and Rules, see page 10; for complete procedure description, see page 22)

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

OFFICE SERVICES – ALL PHYSICIANS

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		ESTABLISHED PATIENT	
Procedure Code	Maximum Fee-NYS	Procedure Code	Maximum Fee-NYS
99201	$ 30.00	99201	$ 30.00
99202	30.00	99202	30.00
99203	30.00	99203	30.00
99204	30.00	99204	30.00
99205	30.00	99205	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-NYS	Procedure Code	Maximum Fee-NYS
99201	$ 6.50	99201	$ 5.00
99202	6.50	99202	5.00
99203	6.50	99203	5.00
99204	6.50	99204	5.00
99205	6.50	99205	5.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICE

Procedure Code	Maximum Fee-NYS
99217	$ 5.00

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 6.50
99219	6.50
99220	6.50

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 6.50
99222	6.50
99223	6.50

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 5.00
99232	5.00
99233	5.00

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

Procedure Code	Maximum Fee-NYS
99234	$ 6.50
99235	6.50
99236	6.50

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99238	$ 5.00
99239	5.00

EMERGENCY DEPARTMENT SERVICES

NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99281	$ 6.50
99282	6.50
99283	6.50
99284	6.50
99285	6.50

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99301	$ 8.00
99302	8.00
99303	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.00
99312	7.00
99313	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 8.00
99316	8.00

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

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99321	$ 8.00
99322	8.00
99323	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99331	$ 7.00
99332	7.00
99333	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99341	$ 7.00
99342	7.00
99343	8.00
99344	8.00
99345	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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 page 57.

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99201	$ 10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99217	$ 6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 6.00
99232	6.00
99233	6.00

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

Procedure Code	Maximum Fee-NYS
99234	$ 10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
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-NYS
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-NYS
99251	$ 20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

FOLLOW-UP INPATIENT CONSULTATIONS NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99261	$ 15.00
99262	15.00
99263	15.00

CONFIRMATORY CONSULTATIONS NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99271-99275 with a Place of Service Office, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee-NYS
99271	$ 20.00
99272	20.00
99273	20.00
99274	20.00
99275	20.00

INITIAL INPATIENT CONSULTATIONS NEW OR ESTABLISHED PATIENTS

Procedure Code	Maximum Fee-NYS
99281	$ 10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

FOLLOW-UP INPATIENT CONSULTATIONS NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED

Procedure Code	Maximum Fee-NYS
99301	$ 8.00
99302	8.00
99303	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.00
99312	7.00
99313	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 8.00
99316	8.00

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

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99321	$ 8.00
99322	8.00
99323	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99331	$ 7.00
99332	7.00
99333	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99341	$ 10.00
99342	10.00
99343	12.50
99344	12.50
99345	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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 page 57.

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99201	$ 10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99217	$ 6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 6.00
99232	6.00
99233	6.00

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

Procedure Code	Maximum Fee-NYS
99234	$ 10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99238	$ 6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OF 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-NYS
99241	$ 20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

CONSULTATIONS (BY SPECIALSTS)

INITIAL INPATIENT CONSULTATIONS, NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99251	$ 20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

FOLLOW-UP INPATIENT CONSULTATIONS, ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99261	$ 15.00
99262	15.00
99263	15.00

CONFIRMATORY CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99271-99275 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee-NYS
99271	$ 20.00
99272	20.00
99273	20.00
99274	20.00
99275	20.00

EMERGENCY DEPARTMENT SERVICES
NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99281	$ 10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED

Procedure Code	Maximum Fee-NYS
99301	$ 8.00
99302	8.00
99303	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.00
99312	7.00
99313	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 8.00
99316	8.00

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

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99321	$ 8.00
99322	8.00
99323	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99331	$ 7.00
99332	7.00
99333	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99341	$ 7.00
99342	7.00
99343	8.00
99344	8.00
99345	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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 page 7-60.

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99201	$ 12.50
99202	12.50
99203	12.50
99204	12.50
99205	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99217	$ 7.50

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 12.50
99219	12.50
99220	12.50

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 12.50
99222	12.50
99223	12.50

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 7.50
99232	7.50
99233	7.50

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

Procedure Code	Maximum Fee-NYS
99234	$ 12.50
99235	12.50
99236	12.50

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99238	$ 7.50
99239	7.50

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OF 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-NYS
99241	$ 20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

CONSULTATIONS (BY SPECIALSTS)

INITIAL INPATIENT CONSULTATIONS, NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99251	$ 20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

FOLLOW-UP INPATIENT CONSULTATIONS, ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99261	$ 15.00
99262	15.00
99263	15.00

CONFIRMATORY CONSULTATIONS NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99271-99275 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee-NYS
99271	$ 20.00
99272	20.00
99273	20.00
99274	20.00
99275	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99281	$ 12.50
99282	12.50
99283	12.50
99284	12.50
99285	12.50

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED

Procedure Code	Maximum Fee-NYS
99301	$ 9.00
99302	9.00
99303	9.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.50
99312	7.50
99313	7.50

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 9.00
99316	9.00

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

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99321	$ 10.00
99322	12.50
99323	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99331	$ 10.00
99332	12.50
99333	12.50

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99341	$ 10.00
99342	10.00
99343	12.50
99344	12.50
99345	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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 page 7-60.

NEW PATIENT

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

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99217	$ 7.50

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 15.00
99219	20.00
99220	25.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 15.00
99222	20.00
99223	25.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 7.50
99232	7.50
99233	7.50

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

Procedure Code	Maximum Fee-NYS
99234	$ 15.00
99235	20.00
99236	25.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99238	$ 7.50
99239	7.50

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OF 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-NYS
99241	$ 20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

CONSULTATIONS (BY SPECIALSTS)

INITIAL INPATIENT CONSULTATIONS, NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99251	$ 20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

FOLLOW-UP INPATIENT CONSULTATIONS, ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99261	$ 15.00
99262	15.00
99263	15.00

CONFIRMATORY CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99271-99275 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee-NYS
99271	$ 20.00
99272	20.00
99273	20.00
99274	20.00
99275	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

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

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED

Procedure Code	Maximum Fee-NYS
99301	$ 9.00
99302	9.00
99303	9.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.50
99312	7.50
99313	7.50

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 9.00
99316	9.00

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

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99321	$ 10.00
99322	20.00
99323	25.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99331	$ 15.00
99332	20.00
99333	25.00

HOME SERVICES

NEW PATIENT

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

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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 page 57

NEW PATIENT

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

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99217	$ 7.50

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 15.00
99219	20.00
99220	25.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 15.00
99222	20.00
99223	25.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 7.50
99232	7.50
99233	7.50

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

Procedure Code	Maximum Fee-NYS
99234	$ 15.00
99235	20.00
99236	25.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99238	$ 7.50
99239	7.50

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS NEW OF 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-NYS
99241	$ 20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS, NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99251	$ 20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

FOLLOW-UP INPATIENT CONSULTATIONS, ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99261	$ 15.00
99262	15.00
99263	15.00

CONFIRMATORY CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99271-99275 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee-NYS
99271	$ 20.00
99272	20.00
99273	20.00
99274	20.00
99275	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

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

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED

Procedure Code	Maximum Fee-NYS
99301	$ 8.00
99302	8.00
99303	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.00
99312	7.00
99313	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 8.00
99316	8.00

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

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99321	$ 8.00
99322	8.00
99323	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99331	$ 7.00
99332	7.00
99333	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99341	$ 15.00
99342	15.00
99343	15.00
99344	25.00
99345	25.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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 page 57

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99201	$ 10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99217	$ 6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 6.00
99232	6.00
99233	6.00

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

Procedure Code	Maximum Fee-NYS
99234	$ 10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99238	$ 6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS NEW OF 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-NYS
99241	$ 20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

INITIAL INPATIENT CONSULTATIONS, NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99251	$ 20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

FOLLOW-UP INPATIENT CONSULTATIONS, ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99261	$ 15.00
99262	15.00
99263	15.00

CONFIRMATORY CONSULTATIONS NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99271-99275 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee-NYS
99271	$ 20.00
99272	20.00
99273	20.00
99274	20.00
99275	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99281	$ 10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED

Procedure Code	Maximum Fee-NYS
99301	$ 8.00
99302	8.00
99303	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.00
99312	7.00
99313	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 8.00
99316	8.00

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

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99321	$ 8.00
99322	8.00
99323	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99331	$ 7.00
99332	7.00
99333	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99341	$ 10.00
99342	10.00
99343	12.50
99344	12.50
99345	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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 page 57

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99201	$ 10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99217	$ 6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 6.00
99232	6.00
99233	6.00

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

Procedure Code	Maximum Fee-NYS
99234	$ 10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99238	$ 6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS NEW OF 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-NYS
99241	$ 20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

CONSULTATIONS (BY SPECIALSTS)

INITIAL INPATIENT CONSULTATIONS, NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99251	$ 20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

FOLLOW-UP INPATIENT CONSULTATIONS, ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99261	$ 15.00
99262	15.00
99263	15.00

CONFIRMATORY CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99271-99275 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee-NYS
99271	$ 20.00
99272	20.00
99273	20.00
99274	20.00
99275	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99281	$ 10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED

Procedure Code	Maximum Fee-NYS
99301	$ 8.00
99302	8.00
99303	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.00
99312	7.00
99313	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 8.00
99316	8.00

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

NEW PATIENT		ESTABLISHED PATIENT	
Procedure Code	Maximum Fee-NYS	Procedure Code	Maximum Fee-NYS
99321	$ 8.00	99331	$ 7.00
99322	8.00	99332	7.00
99323	8.00	99333	7.00

HOME SERVICES

NEW PATIENT		ESTABLISHED PATIENT	
Procedure Code	Maximum Fee-NYS	Procedure Code	Maximum Fee-NYS
99341	$ 10.00	99347	$ 10.00
99342	10.00	99348	10.00
99343	12.50	99349	12.50
99344	12.50	99350	12.50
99345	12.50		

PROLONGED SERVICES

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

Procedure Code	Maximum Fee-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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 page 57

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99201	$ 10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99217	$ 6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 6.00
99232	6.00
99233	6.00

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

Procedure Code	Maximum Fee-NYS
99234	$ 10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99238	$ 6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OF 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-NYS
99241	$ 20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

CONSULTATIONS (BY SPECIALSTS)

INITIAL INPATIENT CONSULTATIONS, NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99251	$ 20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

FOLLOW-UP INPATIENT CONSULTATIONS, ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99261	$ 15.00
99262	15.00
99263	15.00

CONFIRMATORY CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99271-99275 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee-NYS
99271	$ 20.00
99272	20.00
99273	20.00
99274	20.00
99275	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99281	$ 10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

PEDIATRIC CRITICAL CARE

PATIENT TRANSPORT

Procedure Code	Maximum Fee-NYS
99289	$ 25.00
99290	12.50

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

Procedure Code	Maximum Fee-NYS
99293	$ 206.00
99294	114.00

NEONATAL CRITICAL CARE

NEONATAL-PERINATAL MEDICINE (155) ONLY

Procedure Code	Maximum Fee-NYS
99295	$ 233.00
99296	115.00

INTENSIVE (NON-CRITICAL) LOW BIRTH WEIGHT SERVICES

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

Procedure Code	Maximum Fee-NYS
99298	$ 57.00
99299	54.00

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99301	$ 8.00
99302	8.00
99303	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.00
99312	7.00
99313	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 8.00
99316	8.00

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

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99321	$ 8.00
99322	8.00
99323	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99331	$ 7.00
99332	7.00
99333	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99341	$ 9.00
99342	9.00
99343	10.00
99344	10.00
99345	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50
99440	25.00

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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 page 7-60.

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99201	$ 10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99217	$ 6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 6.00
99232	6.00
99233	6.00

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

Procedure Code	Maximum Fee-NYS
99234	$ 10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99238	$ 6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS NEW OF 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-NYS
99241	$ 20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

CONSULTATIONS (BY SPECIALSTS)

INITIAL INPATIENT CONSULTATIONS, NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99251	$ 20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

FOLLOW-UP INPATIENT CONSULTATIONS, ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99261	$ 15.00
99262	15.00
99263	15.00

CONFIRMATORY CONSULTATIONS NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99271-99275 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee-NYS
99271	$ 20.00
99272	20.00
99273	20.00
99274	20.00
99275	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99281	$ 10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99301	$ 9.00
99302	9.00
99303	9.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.50
99312	7.50
99313	7.50

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 9.00
99316	9.00

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

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99321	$ 10.00
99322	10.00
99323	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99331	$ 6.00
99332	6.00
99333	6.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99341	$ 10.00
99342	10.00
99343	10.00
99344	10.00
99345	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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 page 57

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99201	$ 10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99217	$ 6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 6.00
99232	6.00
99233	6.00

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

Procedure Code	Maximum Fee-NYS
99234	$ 10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99238	$ 6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OF 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-NYS
99241	$ 20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

CONSULTATIONS (BY SPECIALSTS)

INITIAL INPATIENT CONSULTATIONS, NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99251	$ 20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

FOLLOW-UP INPATIENT CONSULTATIONS, ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99261	$ 15.00
99262	15.00
99263	15.00

CONFIRMATORY CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99271-99275 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee-NYS
99271	$ 20.00
99272	20.00
99273	20.00
99274	20.00
99275	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99281	$ 10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99301	$ 8.00
99302	8.00
99303	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.00
99312	7.00
99313	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 8.00
99316	8.00

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

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99321	$ 8.00
99322	8.00
99323	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99331	$ 7.00
99332	7.00
99333	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99341	$ 7.00
99342	7.00
99343	8.00
99344	8.00
99345	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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 page 57

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99201	$ 12.50
99202	12.50
99203	12.50
99204	12.50
99205	12.50

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99217	$ 6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 12.50
99219	12.50
99220	12.50

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 12.50
99222	12.50
99223	12.50

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 6.00
99232	6.00
99233	6.00

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

Procedure Code	Maximum Fee-NYS
99234	$ 12.50
99235	12.50
99236	12.50

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99238	$ 6.00
99239	6.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99281	$ 17.00
99282	17.00
99283	17.00
99284	17.00
99285	17.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99301	$ 8.00
99302	8.00
99303	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.00
99312	7.00
99313	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 8.00
99316	8.00

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

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99321	$ 8.00
99322	8.00
99323	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99331	$ 7.00
99332	7.00
99333	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99341	$ 7.00
99342	7.00
99343	8.00
99344	8.00
99345	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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 page 57

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99201	$ 10.00
99202	10.00
99203	10.00
99204	10.00
99205	10.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99217	$ 6.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99218	$ 10.00
99219	10.00
99220	10.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99221	$ 10.00
99222	10.00
99223	10.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee-NYS
99231	$ 6.00
99232	6.00
99233	6.00

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

Procedure Code	Maximum Fee-NYS
99234	$ 10.00
99235	10.00
99236	10.00

HOSPITAL DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99238	$ 6.00
99239	6.00

CONSULTATIONS (BY SPECIALISTS)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS
NEW OF 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-NYS
99241	$ 20.00
99242	20.00
99243	20.00
99244	20.00
99245	20.00

CONSULTATIONS (BY SPECIALSTS)

INITIAL INPATIENT CONSULTATIONS, NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99251	$ 20.00
99252	20.00
99253	20.00
99254	20.00
99255	20.00

FOLLOW-UP INPATIENT CONSULTATIONS, ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99261	$ 15.00
99262	15.00
99263	15.00

CONFIRMATORY CONSULTATIONS
NEW OR ESTABLISHED PATIENT

When reporting procedure codes 99271-99275 with a Place of Service **Office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule Amount.

Procedure Code	Maximum Fee-NYS
99271	$ 20.00
99272	20.00
99273	20.00
99274	20.00
99275	20.00

EMERGENCY DEPARTMENT SERVICES NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99281	$ 10.00
99282	10.00
99283	10.00
99284	10.00
99285	10.00

CRITICAL CARE SERVICES

Procedure Code	Maximum Fee-NYS
99291	$ 25.00
99292	12.50

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99301	$ 8.00
99302	8.00
99303	8.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99311	$ 7.00
99312	7.00
99313	7.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee-NYS
99315	$ 8.00
99316	8.00

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

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99321	$ 8.00
99322	8.00
99323	8.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
99331	$ 7.00
99332	7.00
99333	7.00

HOME SERVICES

NEW PATIENT

Procedure Code	Maximum Fee-NYS
99341	$ 9.00
99342	9.00
99343	9.00
99344	9.00
99345	9.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee-NYS
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-NYS
99354	$ 25.00
99355	12.50
99356	25.00
99357	12.50

NEWBORN CARE

Procedure Code	Maximum Fee-NYS
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

Procedure Code	Maximum Fee Co. Group A	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

Procedure Code	Maximum Fee Co. Group A	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

HOSPITAL OUTPATIENT SERVICES

Reimbursment 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

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

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99301	$ 36.00	$ 30.00
99302	36.00	30.00
99303	36.00	30.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99311	$ 36.00	$ 30.00
99312	36.00	30.00
99313	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
99321	$ 36.00	$ 30.00
99322	36.00	30.00
99323	36.00	30.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99331	$ 36.00	$ 30.00
99332	36.00	30.00
99333	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	Procedure Code	Maximum Fee Co. Group A	Co. Group B
99201	$ 42.22	$ 37.35	99211	$ 42.22	$ 37.35
99202	42.22	37.35	99212	42.22	37.35
99203	42.22	37.35	99213	42.22	37.35
99204	42.22	37.35	99214	42.22	37.35
99205	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

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99301	$ 36.00	$ 30.00
99302	36.00	30.00
99303	36.00	30.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99311	$ 36.00	$ 30.00
99312	36.00	30.00
99313	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
99321	$ 36.00	$ 30.00
99322	36.00	30.00
99323	36.00	30.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99331	$ 36.00	$ 30.00
99332	36.00	30.00
99333	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

DRUG ADMINISTRATION

IMMUNIZATION INJECTIONS

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 that 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.

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
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

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	Diptheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use
90702	Diptheria 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
90712	Poliovirus vaccine, (any type(s)) (OPV), live, for oral use
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous 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	Diptheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
90721	Diptheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use
90723	Diptheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-Hep B-IPV), for intramuscualr use
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	Meningococococcal 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

	Hepatitis B vaccine;	
90746	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	BR

THERAPEUTIC OR DIAGNOSTIC INFUSIONS (EXCLUDES CHEMOTHERAPY)

These procedures encompass prolonged intravenous injections. These codes require the presence of the physician during the infusion. 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 prolonged services codes.

90780	Intravenous infusion therapy/diagnosis administered by physician or under direct supervision of physician; up to one hour	$ 35.00
90781	each additional hour, up to eight (8) hours	$5.00

THERAPEUTIC PROPHYLACTIC OR DIAGNOSTIC INJECTIONS

90799	Unlisted therapeutic, prophylactic or diagnostic injection (injectable material)	BR

DRUGS ADMINISTERED OTHER THAN ORAL METHOD

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.

THERAPEUTIC INJECTIONS

(Maximum fee includes cost of material)

A4216	Sterile water/saline, 10 ml	
A4260	Levonorgestrel contraceptive implants system (Norplant System), including implants and supplies	BR
A4647	Supply of paramagnetic contrast material (eg, gadolinium)(per ml)	
J0135	Adalimumab, 20 mg	
J0150	Injection, adenosine for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use A9270)	

J0170 Adrenalin, Epinephrine, up to 1 ml ampule
J0180 Agalsidase beta, 1 mg
J0205 Alglucerase, per 10 units
J0207 Amifostine, 500 mg
J0210 (Aldomet) Methyldopate HCL, 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, excludes self-administration)
J0275 Alprostadil urethral suppository (administered under direct supervision of a physician, not for self-administration)
J0280 Aminophyllin, up to 250 mg
J0290 Ampicillin Sodium, up to 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 100 Units
J0587 Botulinum toxin type B, per 100 Units
J0600 (Calcium Disodium Versenate) Edetate Calcium Disodium, up to 1000 mg
J0610 Calcium Gluconate, per 10 ml
J0620 Calcium Glycerophosphate and Calcium Lactate, per 10 ml
J0630 (Calcimar) Calcitonin-Salmon, up to 400 units
J0636 Calcitrol, 0.1 mcg
J0640 Leucovorin Calcium, per 50 mg
J0690 Cefazolin Sodium, up to 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
J0713 Ceftazidime, per 500 mg
J0715 Ceftizoxime Sodium, per 500 mg
J0720 (Chloromycetin Sodium Succinate) Chloramphenicol 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 (Coly-Mycin M) Colistimethate Sodium, up to 150 mg
J0780 (Compazine) Prochlorperazine, up to 10 mg
J0835 Cosyntropin, per 0.25 mg
J0895 Deferoxamine Mesylate, 500 mg
J0900 Testosterone Enanthate and Estradiol Valerate, up to 1 cc
J0945 Brompheniramine maleate, per 10 mg
J0970 (Delestrogen) Estradiol Valerate, up to 40 mg
J1000 Depo-Estradiol Cypionate, up to 5 mg
J1020 (Depo-Medrol) Methylprednisolone Acetate, 20 mg
J1030 (Depo-Medrol) Methylprednisolone Acetate, 40 mg
J1040 (Depo-Medrol) Methylprednisolone Acetate, 80 mg
J1051 (Depo-Provera Aq.) Medroxyprogesterone Acetate, 50 mg
J1055 (Depo-Provera Ag.) Medroxyprogesterone Acetate for contraceptive use, 150 mg
J1056 Medroxyprogesterone acetate/estradiol cypionate, 5 mg/25mg
J1060 (Depo-Testadiol) Testosterone Cypionate and Estradiol Cypionate, up to 1 ml
J1070 (Depo-Testosterone Cypionate) Testosterone Cypionate, up to 100 mg
J1080 (Depo-Testosterone Cypionate) 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 (Elavil HCL) Amitriptyline 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	
J1410	Estrogen Conjugated, per 25 mg	
J1435	Estrone, per 1 mg	
J1436	Etidronate Disodium, per 300 mg	
J1438	Etanercept, 25 mg, (administered under direct supervision of physician, not self administered)	
J1440	Filgrastim (G-CSF), 300 mcg	
J1441	Filgrastim (G-CSF), 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	(Haldol) Haloperidol, up to 5 mg	
J1631	(Haldol) Haloperidol Decanoate, 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	(Hydrocortone Phosphate) Hydrocortisone Sodium Phosphate, up to 50 mg	
J1720	Hydrocortisone Sodium Succinate, (Solu-Cortef) up to 100 mg	
J1730	(Hyperstat) Diazoxide, up to 300 mg	
J1745	Infliximab, 10 mg	
J1750	Iron dextran, 50 mg	
J1756	Iron Sucrose, 1 mg	
J1785	Imiglucerase, per Unit (per vial)	BR
J1790	Droperidol, up to 5 mg	
J1800	(Inderal) Propranolol HCL, up to 1 mg	
J1815	Insulin, per 5 units	
J1817	Insulin (i.e., insulin pump) per 50 units	
J1825	Interferon beta-1a, 33 mcg	
J1830	Interferon Beta-1b, 0.25 mg, (administered under direct physician supervision, not for self-administration)	
J1840	(Kantrex) Kanamycin Sulfate, up to 500 mg	
J1850	(Kantrex Pediatric) Kanamycin Sulfate, up to 75 mg	
J1885	Ketorolac Tromethamine, per 15 mg	
J1890	(Keflin) Cephalothin Sodium, up to 1 gm	
J1931	Laronidase, 0.1 mg	
J1940	(Lasix) Furosemide, up to 20 mg	
J1950	Leuprolide Acetate (for depot suspension), per 3.75 mg	

J1955 Levocarnitine, per 1 gm
J1960 (Levo-Dromoran) Levorphanol Tartrate, up to 2 mg
J1980 (Levsin) Hyoscyamine Sulfate, up to 0.25 mg
J1990 (Librium) Chlordiazepoxide HCL, up to 100 mg
J2001 Lidocaine HCL for intravenous infusion, 10 mg
J2010 (Lincocin) Lincomycin HCL up to 300 mg
J2060 Lorazepam, 2 mg
J2150 Mannitol, 25% in 50 ml
J2175 Meperidine Hydrochloride, per 100 mg
J2210 (Methergine Maleate) Methylergonovine Maleate, up to 0.2 mg
J2260 Milrinone lactate, per 5 ml
J2270 Morphine Sulfate, up to 10 mg
J2275 Morphine Sulfate (preservative-free sterile solution), per 10 mg
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 (Norflex) Orphenadrine, up to 60 mg
J2370 (Neo-Synephrine) Phenylephrine HCL, up to 1 ml
J2405 Odansetron Hydrochloride (Zofran), per 1 mg
J2410 (Numorphan) Oxymorphone HCL, up to 1 mg
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
J2505 Pegfilgrastim (Neulasta), 6 mg
J2510 Penicillin G Procaine, Aqueous, up to 600,000 Units
J2515 Pentobarbital Sodium, per 50 mg
J2540 (Pfizerpen) Penicillin G Potassium, up to 600,000 Units
J2545 Pentamidine Isethionate, inhalation solution, per 300 mg
J2550 (Phenergan) Promethazine HCL, up to 50 mg
J2560 Phenobarbital Sodium, up to 120 mg
J2590 (Pitocin) Oxytocin, up to 10 Units
J2597 Desmopressin Acetate, per 1 mcg
J2650 Prednisolone Acetate, up to 1 ml
J2670 (Priscoline HCL) Tolazoline HCL, up to 25 mg
J2675 Progesterone (injection), per 50 mg
J2680 (Prolixin Decanoate) Fluphenazine Decanoate, up to 25 mg
J2690 (Pronestyl) Procainamide HCL, up to 1 gm
J2700 (Prostaphlin) Oxacillin Sodium, up to 250 mg
J2710 (Prostigmin) Neostigmine Methylsulfate, up to 0.5 mg
J2720 Protamine Sulfate, per 10 mg
J2730 (Protopam Chloride) Pralidoxime Chloride, up to 1 gm
J2760 (Regitine) Phentolamine Mesylate, up to 5 mg

J2765 (Reglan) Metoclopramide HCL, up to 10 mg
J2780 Ranitidine HCL, 25 mg
J2783 Rasburicase, 0.5 mg
J2794 Risperidone, long acting, 0.5 mg
J2800 (Robaxin) Methocarbamol, up to 10 ml
J2820 Sargramostim (GM-CSF), 50 mcg
J2910 (Solganal) Aurothioglucose, up to 50 mg
J2912 Sodium Chloride, 0.9%, per 2 ml
J2920 (Solu-Medrol) Methylprednisolone Sodium Succinate, up to 40 mg.
J2930 (Solu-Medrol) Methylprednisolone Sodium Succinate, 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 (Talwin) Pentazocine HCL, 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 (Thorazine) Chlorpromazine HCL, up to 50 mg
J3240 Thyrotropin alpha 0.9 mg. Provided in 1.1 mg vial (Thyrogen)
J3250 (Tigan) Trimethobenzamide HCL, up to 200 mg
J3260 Tobramycin Sulfate, (Nebcin) up to 80 mg
J3265 Torsemide, 10 mg/ml
J3280 (Torecan) Thiethylperazine Maleate, up to 10 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 (Trilafon) Perphenazine, up to 5 mg
J3315 Triptorelin pamoate, 3.75 mg
J3320 (Trobicin) Spectinomycin Dihydrochloride, up to 2 gm
J3360 (Valium) Diazepam, up to 5 mg
J3364 Urokinase, 5,000 IU vial
J3370 Vancomycin HCL, up to 500 mg
J3396 Verteporfin (Visudyne), 0.1 mg
J3400 (Vesprin) Triflupromazine HCL, up to 20 mg
J3410 (Vistaril) Hydroxyzine HCL, 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
J3470 (Wydase) Hyaluronidase, up to 150 Units
J3475 Magnesium sulfate, per 500 mg
J3480 Potassium Chloride, per 2 mEq

J3487	Zoledronic acid, 1 mg	
J3520	Edetate Disodium, per 150 mg	
J3590	Unclassified biologicals	BR

MISCELLANEOUS DRUGS AND SOLUTIONS

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	
J7051	Sterile saline or water, up to 5 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	
J7308	Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)	
J7317	Sodium hyaluronate, per 20-25 mg dose (for intra-articular injection)	
J7320	Hylan G-F 20, 16 mg, for intra-articular injection	
J7340	Dermal and epidermal, tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements, per sq. cm.	BR
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	
J7616	Albuterol, up to 5 mg and ipratropium bromide, up to 1 mg, compounded inhalation solution, administered through DME	
J7628	Bitolterol mesylate, inhalation solution, concentrated form, per mg	
J7631	Cromolyn sodium, inhalation solution, unit dose form, per 10 mg	
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
Q0136	Epoetin Alpha, (for non-ESRD) use), per 1000 units	
Q0137	Darbepoetin alfa, 1 mcg (non-ESRD use)	
Q2012	Pegademase bovine, 25 IU	
Q3031	Collagen skin test	BR
90799	Unlisted therapeutic, prophylactic or diagnostic injection (injectable material)	BR

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, 96100, 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 on page 13 and 14.

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
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
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 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
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); single seizure	$36.00
90871	multiple seizures, per day	$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
90920	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

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
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

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

		Anest	
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

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.

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 (For surgical use of contact lens, see 68340)	$65.00

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.

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; see 99070 for the supply of other materials.

92390	Supply of spectacles, except prosthesis for aphakia and low vision aids	BR
92392	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.)	BR
92395	Supply of permanent prosthesis for aphakia; spectacles (For temporary spectacle correction for aphakia, see 92358)	BR
92499	UNLISTED ophthalmological service or procedure	BR

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.

		Anest	
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

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	$10.00
92569	Acoustic reflex decay test	$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 (To report augmentative and alternative communication device services, see 92605, 92607, 92608)	$24.00

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

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 code for primary procedure) (Use 92608 in conjunction with 92607)	$6.00
92609	Therapeutic services for the use of speech-generating device, including programming and modification (For therapeutic service(s) for the use of a non-speech generating device, use 92606)	$17.00
92610	Evaluation of oral and pharyngeal swallowing function For motion fluoroscopic evaluation of swallowing function, use 92611) (For flexible endoscopic examination, use 92612-92617)	$12.00
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording (For radiological supervision and interpretation, use 74230) (For evaluation of oral and pharyngeal swallowing function, use 92610)	$13.00
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording (If flexible fiberoptic or endoscopic evaluation of swallowing is performed without cine or video recording, use 92700)	$51.00
92613	physician interpretation and report only (To report an evaluation of oral and pharyngeal swallowing function, use 92610) (To report motion fluoroscopic evaluation of swallowing function, use 92611)	$20.00
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)

		Anest	
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)	3.0+T	$72.00
	(Do not report 92961 in addition to codes 93662; 93618-93624, 93631, 93640-93642, 93650-93652, 93741-93744)		
92970	Cardioassist-method of circulatory assist; internal		$58.00
92971	external		$30.00
92973	Percutaneous transluminal coronarythrombectomy (List separately in addition to code for 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 code for primary procedure) (Use 92974 in conjunction with codes 92980, 92982, 93508) (For intravascular radioelement application, see 77781 – 77784)		$59.00
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		$50.00
	(List 92978 & 92979 separately in addition to code for primary code; use 92979 in conjunction with code 92978) (Intravascular ultrasound services include all transducer manipulations and repositioning within the specific vessel being examined, both before and after therapeutic intervention (eg, stent placement))		

			Follow Up Days
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	$125.00	
	(Use 92984 in conjunction with code(s) 92980, 92982, 92995)(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	$372.00	90
92987	mitral valve	$386.00	90
92990	pulmonary valve	$400.00	90
92992	Atrial septectomy or septostomy; transvenous method, balloon, (eg, Rashkind type) (includes cardiac catheterization)	$270.00	90
92993	blade method (Park septostomy) (includes cardiac catheterization)	$270.00	90
92995	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel	$218.00	
92996	each additional vessel	$59.00	
	(Use 92996 in conjunction with code(s) 92980, 92982, 92995)		
	(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 code for 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
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 (For implanted patient activated cardiac event recording, see 33282, 93727)	$42.00
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)

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.

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.

			Follow Up Days
93501	Right heart catheterization (For bundle of His recording, see 93600)	$140.00	7
93503	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes	$140.00	7
93505	Endomyocardial biopsy	$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)	$207.00	7
93510	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous	$80.00	7
93511	by cutdown	$80.00	7
93514	Left heart catheterization by left ventricular puncture	$80.00	7
93524	Combined transseptal and retrograde left heart catheterization	$160.00	7
93526	Combined right heart catheterization and retrograde left heart catheterization	$180.00	7
93527	Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)	$180.00	7
93528	Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)	$140.00	7

			Follow Up Days
93529	Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)	$140.00	7
93530	Right heart catheterization, for congenital cardiac anomalies	$140.00	7
93531	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	$180.00	7
93532	Combined right heart catheterization and transseptal left heart catherization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies	$180.00	7
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	$180.00	7

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.

			Anest
93539	Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass	$28.00	3.0+T
93540	for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries	$28.00	3.0+T
93541	for pulmonary angiography	$20.00	3.0+T
93542	for selective right ventricular or right atrial angiography	$20.00	3.0+T
93543	for selective left ventricular or left atrial angiography	$20.00	3.0+T
93544	for aortography	$100.00	3.0+T
93545	for selective coronary angiography (injection of radiopaque material may be by hand)	$20.00	3.0+T
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 (For radioisotope method of cardiac output, see 78472, 78473 or 78481)	$12.50	
93571	Intravscular 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 code for primary procedure)	$80.00	
93572	each additional vessel (List separately in addition to code for 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

			Follow Up Days
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)	$285.00	7
93581	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant (Percutaneous transcatheter closure of ventricular septal defect (ie, fontan fenestration) 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 as appropriate)	$381.00	7

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.

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 (Use 93609 in conjunction with codes 93620, 93651, 93652) (List separately in addition to code for primary procedure)	$184.00
93610	Intra-atrial pacing	$75.00
93612	Intraventricular pacing (Do not report 93612 in conjunction with codes 93620-93622)	$78.00
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 with 93600, 93602, 93610, 93612, 93618, or 93620-22)	$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, 93612, 93618 or 93619)	$363.00
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 effect	$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 (For subsequent or periodic electronic analysis and/or reprogramming of single or dual chamber pacing cadioverter-defibrillators, see 93642, 93741-93744)	$227.00

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
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 code for 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

MISCELLANEOUS 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

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 (For central venous cannulization and pressure measurements, see 36488-36491, 36500)	$5.00
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.

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, 93965, 93922, 93923 and 93924 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

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) (For measurement of hemodialysis access flow using indicator dilution methods, use 90940)	$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 36488-36491)
(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
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 (For prolonged exercise test for bronchospasm with pre and post-spirometry use 94620)	$25.00

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
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)	$42.00
	(Separate procedure codes for electromyograms, EEG, ECG, and recordings of respiration are excluded when 94772 is reported)	
94799	Unlisted pulmonary service or procedure	BR

ALLERGY AND CLINICAL IMMUNOLOGY

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
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
86585	tuberculosis, tine test	$1.88
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 (99241-99263) 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 (95805-95827) 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)

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
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
95858	with electromyographic recording	$45.00

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

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

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 (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.)	$45.00

(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

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

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
95973	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 code for 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 code for primary procedure) (Use 95975 in conjunction with code 95974)	$27.00
95991	Spinal (intrathecal, epidural) or brain (intraventricular); administered by physician	$15.00
	(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 96530)	
95999	Unlisted neurological or neuromuscular diagnostic procedure	BR

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 96100 through 96117, 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 on pages 13 and 14.

96100	Psychological testing (includes psycho-diagnostic assessment of personality,psychopathology, emotionality, intellectualabilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, (face-to-face with the patient) per hour	$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
96115	Neurobehavorial status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour	$150.00
96117	Neurospsychological testing battery (eg, Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour	$150.00

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) 96408-96425 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 90780-90788, as appropriate.

96405	Chemotherapy administration, intralesional; up to and including 7 lesions	$10.00
96406	more than 7 lesions	$15.00
96408	Chemotherapy administration, intravenous; push technique	$15.00
96410	infusion technique, up to one hour	$35.00
96412	infusion technique, one to 8 hours, each additional hour (Use 96412 in conjunction with code 96410)	$5.00

96414	infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	$35.00
96420	Chemotherapy administration, intra-arterial; push technique	$15.00
96422	infusion technique, up to one hour	$35.00
96423	infusion technique, one to 8 hours, each additional hour (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
96450	Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture (For intravesical (bladder) chemotherapy administration, see 51720; 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
96520	Refilling and maintenance of portable pump	$15.00
96530	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (intravenous, intra-arterial) (Access of pump port is included in filling of implantable pump) (For collection of blood specimen from a partially or completely implantable venous access device, use 36540)	$15.00
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	$15.00
96545	Provision of chemotherapy agent (not otherwise listed) (For radioactive isotope therapy, see 79000-79999)	BR
96549	Unlisted chemotherapy procedure	BR

CHEMOTHERAPY DRUGS

(Maximum fee is for chemotherapy drug only and does not include the administration)

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 (Adriamycin) Doxorubicin HCL, 10 mg
J9001 Doxorubicin hydrochloride, all lipid formulations, 10 mg
J9010 Alemtuzumab, 10 mg
J9015 Aldesleukin, per single use vial
J9017 Arsenic trioxide, 1 mg (Trisenox)
J9020 Asparaginase (Elspar) 10,000 Units
J9031 BCG live (intravesical), per installation
J9035 Bevacizumab, 10 mg
J9040 (Lenoxane) Bleomycin Sulfate, 15 units
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) 1.0 gm
J9092 Cyclophosphamide (Cytoxan, Neosar) 2.0 gm
J9093 Cyclophosphamide, Lyophilized (Cytoxan) 100 mg
J9094 Cyclophosphamide, Lyophilized (Cytoxan) 200 mg
J9095 Cyclophosphamide, Lyophilized (Cytoxan) 500 mg
J9096 Cyclophosphamide, Lyophilized (Cytoxan) 1.0 gm
J9097 Cyclophosphamide, Lyophilized (Cytoxan) 2.0 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
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	
J9219	Leuprolide Acetate Implant, 65 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	
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
Q0136	Epoetin alpha, (for non ESRD use), per 1000 units	
Q0165	Prochlorperazine maleate, 10 mg, oral	
Q0174	Thiethylperazine maleate, 10 mg, oral	
Q0177	Hydroxyzine pamoate, 25 mg, oral	
Q2017	Teniposide, 50 mg	
96545	Provision of chemotherapy agent (not listed above)	BR

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	$15.00
	(96570, 96571 are to be used in addition to bronchoscopy, endoscopy codes) (To report ocular photodynamic therapy, use 67221)	
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) (Use 96570, 96571 in conjunction with codes 31641, 43228 as appropriate)	$8.50

SPECIAL DERMATOLOGICAL PROCEDURES

Dermatologic services are typically consultative, and any of the levels of consultation (99241-99263) 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

99052	Services requested between 10:00 PM and 8:00 AM in addition to basic service (Procedure code 99052 is not reimbursable when the Practitioner is contractually obligated to provide the basic service (eg, emergency room physicians, etc.))	$5.00
99070	Supplies and materials (except spectacles), 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) (For spectacles, see 92390-92395)	BR
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 code for 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.

SEDATION WITH OR WITHOUT ANALGESIA (C0NSCIOUS SEDATION)

Sedation with or without analgesia (conscious sedation) is used to achieve a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and ability to respond to stimulation or verbal commands. Conscious sedation includes performance and documentation of pre- and post-sedation evaluations of the patient, administration of the sedation and/or analgesic agent(s), and monitoring of cardiorespiratory function (i.e., pulse oximetry, cardiorespiratory monitor, and blood pressure). The use of these codes requires the presence of an independent trained observer to assist the physician in monitoring the patient's level of consciousness and physiological status. Do not report the procedure specific code with an anesthesia modifier in addition to codes 99141, 99142.

99141	Sedation with or without analgesia (conscious sedation); **(15 minutes = 1 unit)** intravenous, intramuscular or inhalation	$5.00
99142	oral, rectal and/or intranasal	$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 conscious sedation, see codes 99141, 99142.

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.
2. Calculated values for anesthesia services are to be used only when the anesthesia is administered by a physician who remains in constant attendance during the procedure for the sole purpose of rendering such anesthesia service.
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 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, 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. The second (bilateral) surgical procedure is identified by adding 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.)**

SURGERY SERVICES

			Anest
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)		
INTEGUMENTARY 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	$4.00	3.0+T
	(If imaging guidance is performed, see 76360,76393, 76942)		
10180	Incision and drainage, complex, postoperative wound infection	$16.00	3.0+T
	(For secondary closure of surgical wound, see 12020, 12021, 13160)		
EXCISION - DEBRIDEMENT			
	(For dermabrasions, see 15780-15791) (For nail debridement, see 11720-11721) (For burn(s), see 16000-16035)		
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	$4.00	
	(List separately in addition to primary procedure)		

			Follow Up Days	Anest
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 code for 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)			
	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.

			Follow Up Days	Anest
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).

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).

			Follow Up Days	Anest
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
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.

			Follow Up Days	Anest
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
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)

			Follow Up Days	Anest
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 (For skin graft, if used, see 15050)	$80.00	45	3.0+T
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) (For incision of pilonidal cyst, see 10080-81)	$20.00	30	3.0+T
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 (11900, 11901 are not to be used for preoperative local anesthetic injection) (For veins, see 36470, 36471, for intralesional chemotherapy administration, see 96405, 96406)	$12.00		3.0+T
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

			Anest
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 (For breast reconstruction with tissue expander(s), see 19357)	$50.00	3.0+T
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	
A4260	Levonorgestrel contraceptive implants system (Norplant System), including implants and supplies	BR	
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	
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)

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.

			Anest
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

			Follow Up Days	Anest
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
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)(For 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		

			Follow Up Days	Anest
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
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	$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	
13153	each additional 5 cm or less (List separately in addition to primary procedure)	$40.00		

(see also 40650-40654, 67961-67975)

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

			Follow Up Days	Anest
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

FREE SKIN GRAFTS

Identify graft by size and location of the defect (recipient area) and the type of graft; procedure includes simple debridement of granulations 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.

Use 15000 for initial wound preparation.

Use 15100-15261 for autogenous skin grafts. For autogenous tissue-cultured skin grafts. These codes include harvesting of keratinocytes and their subsequent application. Procedures are coded by recipient site. Use codes 15342 and 15343 for application of skin substitute/neodermis.

For tissue-cultured skin grafts, including bilaminate skin substitutes/neodermis, use 15000 for initial wound preparation. Codes 15342, 15343 include application. Procedures are coded by recipient site.

The repair of donor site graft or local flaps is considered an additional separate procedure.

Codes 15000, 15001, 15350, 15351, 15400, 15401 describe burn and wound preparation and management procedures. The following definition should be applied to codes 15000, 15001, 15100, 15101, 15120, 15121 when determining the involvement of body size. The measurement of 100 sq cm is applicable to adults and children age 10 and over, percentages apply to infants and children under the age of 10.

(For microvascular flaps, see 15756-15758)
(List the free graft separately by its procedure number when the graft, immediately or delayed, is applied.)

15000	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children (For appropriate skin grafts, see 15050-15261; list the free graft separately by its procedure number when the graft, immediate or delayed, is applied)	$40.00	30	3.0+T
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		

			Follow Up Days	Anest
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 graft, trunk, arms, legs; first 100 sq cm or less, or each 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	$39.00	45	
15120	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or each 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	$66.00	45	
	(For eyelids, see also 67961 et seq)			
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)			
15342	Application of bilaminate skin substitute/neodermis; 25 sq cm	$39.00	10	3.0+T
15343	each additional 25 sq cm (List separately in addition to primary procedure)	$7.00		
	(Use 15343 in conjunction with code 15342)			

			Follow Up Days	Anest
15350	Application of allograft, skin; 100 sq cm or less	$70.00	45	3.0+T
15351	each additional 100 sq cm (List separately in addition to primary procedure)	$22.00		
15400	Application of xenograft, skin; 100 sq cm or less	$66.00	45	3.0+T
15401	each additional 100 sq cm (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)			
15600	Delay of flap or sectioning of flap (division and inset); at trunk	$60.00	45	
15610	at scalp, arms, or legs	$88.00	45	
15620	at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet	$120.00	45	
15630	at eyelids, nose, ears, or lips	$148.00	45	
15650	Transfer, intermediate, of any pedicle flap (eg, abdomen to wrist, Walking tube), any location	$160.00	45	
	(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)			

			Follow Up Days	Anest
15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, massetermuscle, sternocleidomastoid, levator scapulae)	$310.00	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 (For strip transplant, use 15220)	BR		3.0+T
	MISCELLANEOUS			
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
15786	Abrasion; single lesion (eg, keratosis, scar)	$8.00		3.0+T
15787	each additional four lesions or less (List separately in addition to code for 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
15810	Salabrasion; 20 sq cm or less	$93.00		3.0+T
15811	over 20 sq cm	$104.00		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

			Follow Up Days	Anest
15822	Blepharoplasty, upper eyelid;	$123.00		3.0+T
15823	with excessive skin weighting down lid	$163.00		3.0+T
	(For blepharoplasty, see also 67916, 67917, 67923, 67924)			
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
15860	Intravenous injection of agent (eg, fluorescein) to test vascular flow in flap or graft	$39.00		3.0+T

			Anest
15876	Suction assisted lipectomy; head and neck	BR	3.0+T
15877	trunk	BR	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 (For free skin graft to close ulcer or donor site, see 15000 et seq)	BR	

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	

		Anest
16010	Dressings and/or debridement, initial or subsequent; under anesthesia, small	$16.00
16015	under anesthesia, medium or large, or with major debridement	$40.00
16020	without anesthesia, office or hospital, small	$8.00
16025	without anesthesia, medium (eg, whole face or whole extremity)	$12.00
16030	without anesthesia, large (eg, more than one extremity)	$16.00
16035	Escharotomy; initial incision	$73.00
16036	each additional incision (List separately in addition to primary procedure)	$25.00

(Use 16036 in conjunction with code 16035)
(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)

			Follow Up Days	Anest
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	$120.00	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

			Follow Up Days	Anest
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 code for 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)			
	MISCELLANEOUS			
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

			Follow Up Days	Anest
19000	Puncture aspiration of cyst breast;	$8.00		3.0+T
19001	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) (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)	$60.00		3.0+T
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	$51.00		
	(Use 19126 in conjunction with code 19125)			
19140	Mastectomy for gynecomastia	$60.00	30	3.0+T

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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 (For preparation of custom breast implant, see 19396)	$300.00	90	3.0+T
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 (For insertion of prosthesis, use also 19340 or 19342)	$430.00	90	3.0+T
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 (For insertion of prosthesis, use also 19340 or 19342)	$570.00	90	3.0+T
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.

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.

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

			Follow Up Days	Anest
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

			Follow Up Days	Anest
20206	Biopsy, muscle, percutaneous needle (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)	$20.00	7	3.0+T
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) (For bone marrow biopsy, use 38221) (For radiological supervision and interpretation, see 76003, 76360, 76393)	$40.00	7	4.0+T
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) (For radiological supervision and interpretation, see 76080)	$5.00		3.0+T
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") (If imaging guidance is performed, see 76003, 76393, 76942)	$8.00		3.0+T

			Follow Up Days	Anest
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) (If imaging guidance is performed, see 76003, 76360, 76393, 76942)	$12.00		3.0+T
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

			Follow Up Days	Anest
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

Codes 20930-20938 are reported in addition to codes for the definitive procedure(s). Report only one bone graft code per operative session.

			Follow Up Days	Anest
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		
	MISCELLANEOUS			
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	$12.00		3.0+T
20972	metatarsal	$75.00		3.0+T
20973	great toe with web space	$100.00		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

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)

			Follow Up Days	Anest
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 (For excision of benign tumor or cyst of mandible requiring osteotomy, see 21046-21047)	$40.50	30	3.0+T
21044	Excision of malignant tumor of mandible;	$300.00	90	6.0+T
21045	radical resection (For bone graft, see 21215)	$430.00	90	6.0+T
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

			Follow Up Days	Anest
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, see 70332)
(Do not report 76003 in addition to 70332)

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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 (For malar augmentation with bone graft, see 21210)	$280.00	90	9.0+T
21275	Secondary revision of orbitocraniofacial reconstruction	$300.00	90	9.0+T
21280	Medial canthopexy (separate procedure) (For medial canthoplasty, see 67950)	$8.00		3.0+T
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 (For operative repair, see 62000-62010)	BR		3.0+T
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

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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

			Follow Up Days	Anest
21485	complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	BR	90	3.0+T
21490	Open treatment of temporomandibular dislocation (For interdental wire fixation, see 21497)	$160.00	90	3.0+T
21493	Closed treatment of hyoid fracture; without manipulation	BR	90	4.0+T
21494	with manipulation	BR	90	4.0+T
21495	Open treatment of hyoid fracture (For treatment of fracture of larynx, see 31584-31586)	BR	90	4.0+T
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 (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)	$100.00	30	3.0+T
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

			Follow Up Days	Anest
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 (For transection of spinal accessory and cervical nerves, see 63191, 64722)	$140.00	60	3.0+T
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 (For sternoclavicular dislocation, see 23520-23532)	$200.00	30	3.0+T
21899	Unlisted procedure, neck or thorax	BR		3.0+T
	BACK AND FLANK			
	EXCISION			
21920	Biopsy, soft tissue of back or flank; superficial	$20.00	15	3.0+T
21925	deep (For needle biopsy of soft tissue, see 20206)	$40.00	30	3.0+T
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.

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)

			Follow Up Days	Anest
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)	$53.00		
	(Use 22103 in conjunction with codes 22100, 22101, 22102)			
22110	Partial excision of vertebral body for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical	$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	$53.00		
	(List separately in addition to primary procedure)			
	(Use 22116 only for codes 22110, 22112, 22114)			

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.

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)	$129.00		
	(Use 22226 only for codes 22220,22222,22224)			

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.

			Follow Up Days	Anest
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
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)	$105.00		

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

			Follow Up Days	Anest
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)	$35.00	10	

(Use 22522 in conjunction with codes 22520, 22521 as appropriate)
(For radiological supervision and interpretation, see 76012, 76013)

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		

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.

ARTHRODESIS, 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.

			Follow Up Days	Anest
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-Cl-C2(atlas-axis), with or without excision of odontoid process (For intervertebral disk excision by laminotomy or laminectomy, see 63020-63042. For arthrodesis, see 22548-22632)	$544.00	270	7.0+T
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 (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		

			Follow Up Days	Anest
	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. 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.

			Follow Up Days	Anest
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 (For spinal cord monitoring use 95925)	$191.00	90	5.0+T
22899	Unlisted procedure, spine	BR		3.0+T

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)

			Follow Up Days	Anest
23000	Removal of subdeltoid calcareous deposits, open (For arthroscopic removal of bursal deposits, use 29999)	$100.00	60	3.0+T
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 (For needle biopsy of soft tissue, use 20206)	$40.00	15	3.0+T
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
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

			Follow Up Days	Anest
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	$400.00	120	3.0+T
	(For replacement with implant, see 23470)			
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)	$120.00		3.0+T
23332	complicated (eg, total shoulder)	BR		3.0+T
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

			Follow Up Days	Anest
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 (For arthroscopic procedure, use 29827)	$200.00	90	3.0+T
23415	Coracoacromial ligament release, with or without acromioplasty (For arthroscopic procedure, use 29826)	$140.00	90	3.0+T
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	$140.00	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	$140.00	90	3.0+T
23455	with labral repair (eg, Bankart procedure) (To report arthroscopic thermal capsulorrhaphy, use 29999)	$140.00	90	3.0+T
23460	Capsulorrhaphy, anterior, any type; with bone block	$345.00	90	3.0+T
23462	with coracoid process transfer (To report open thermal capsulorrhaphy, use 23929)	$320.00	90	3.0+T
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block (For sternoclavicular and acromioclavicular reconstruction, see 23530 and 23550)	$280.00	90	3.0+T
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) (For removal of total shoulder implants, see 23331, 23332) (For osteotomy proximal humerus, see 24400)	$420.00	120	3.0+T
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

			Follow Up Days	Anest
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 traction (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
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

			Follow Up Days	Anest
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
	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

			Follow Up Days	Anest
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)			
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

			Follow Up Days	Anest
	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 (For elbow arthrography, see 73085) (For injection of tennis elbow, see 20550)	$12.00		3.0+T
	REPAIR, REVISION AND/OR RECONSTRUCTION			
24300	Manipulation, elbow, under anesthesia (For application of external fixation, see 20690 or 20692)	$105.00	90	3.0+T
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
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

			Follow Up Days	Anest
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) (For proximal radius and/or ulna, see 25400-25420)	$600.00	180	3.0+T
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

			Follow Up Days	Anest
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
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		3.0+T
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		3.0+T

			Follow Up Days	Anest
24655	with manipulation	$60.00		3.0+T
24665	Open treatment of radial head or neck fracture, with or without internal fixation or radial head excision;	$140.00		3.0+T
24666	with radial head prosthetic replacement	$180.00		3.0+T
24670	Closed treatment of u1nar fracture, proximal end (olecranon process); without manipulation	$40.00		3.0+T
24675	with manipulation	$40.00		3.0+T
24685	Open treatment of u1nar fracture proximal end (olecranon process), with or without internal or external fixation	$160.00		3.0+T
	ARTHRODESIS			
24800	Arthrodesis, elbow joint; local	$280.00		3.0+T
24802	with autogenous graft (includes obtaining graft)	$280.00		3.0+T
	AMPUTATION			
24900	Amputation, arm through humerus; with primary closure	$160.00		3.0+T
24920	open, circular (guillotine)	$140.00		3.0+T
24925	secondary closure or scar revision	$20.00		3.0+T
24930	reamputation	$160.00		3.0+T
24931	with implant	$275.00		3.0+T
24935	Stump elongation, upper extremity	BR		3.0+T
24940	Cineplasty, upper extremity, complete procedure	$300.00		3.0+T
24999	Unlisted procedure, humerus or elbow	BR		3.0+T
	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

			Follow Up Days	Anest
	(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
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

			Follow Up Days	Anest
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)			

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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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
25145	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
24526	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
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

			Follow Up Days	Anest
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 u1nar shaft fracture; without manipulation	$40.00	45	3.0+T
25535	with manipulation	$80.00	120	3.0+T
25545	Open treatment of u1nar shaft fracture, with or without internal or external fixation	$160.00	120	3.0+T
25560	Closed treatment of radial and u1nar 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 u1nar 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 u1nar 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 u1nar 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

			Follow Up Days	Anest
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
25690	Closed treatment of lunate dislocation, with manipulatic	$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

			Follow Up Days	Anest
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
26037	Decompressive fasciotomy, hand (excludes 26035) (For injection injury, see 26035)	$120.00	60	3.0+T
26040	Fasciotomy, palmar, (eg, Dupuytren's contracture); percutaneous	$40.00	60	3.0+T
26045	open, partial(For fasciectomy, see 26121-26125)	$120.00	60	3.0+T
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

			Follow Up Days	Anest
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) (For fasciotomy, see 26040-26045)	$80.00	60	3.0+T
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
26145	Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendor, palm and/or finger, each tendon (For tendon sheath synovectomies at wrist, see 25115, 25116	$120.00	120	3.0+T
26160	Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger (For wrist ganglion, see 25111, 25112) (For trigger digit, see 26055)	$40.00	30	3.0+T
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

			Follow Up Days	Anest
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 (For removal of foreign body in hand or finger, see 20520, 20525)	$100.00	120	3.0+T
	REPAIR, REVISION AND/OR RECONSTRUCTION			
26340	Manipulation, finger joint, under anesthesia, each joint (For application of external fixation, see 20690 or 20692)	$79.00	90	3.0+T
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

			Follow Up Days	Anest
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)			
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

			Follow Up Days	Anest
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
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		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

			Follow Up Days	Anest
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
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 (For excision of polydactylous digit, soft tissue only, use 11200)	$60.00	45	3.0+T
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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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
	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)	$60.00	45	3.0+T
	(For repair of soft tissue defect requiring split or full thickness graft or other pedicle flaps, see 15050-15758)			
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)

			Follow Up Days	Anest
26990	Incision and drainage; deep abscess or hematoma	$40.00	15	3.0+T
26991	infected bursa	$40.00	15	3.0+T
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 (For obturator neurectomy, see 64763, 64766)	BR		3.0+T
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 (For needle biopsy of soft tissue, use 20206)	$40.00	15	3.0+T
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

			Follow Up Days	Anest
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)			
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		3.0+T
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)

REPAIR, REVISION, AND/OR RECONSTRUCTION

			Follow Up Days	Anest
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)	$200.00	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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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
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 (For combined Ober-Yount fasciotomy, see 27025)	$120.00	45	3.0+T

			Follow Up Days	Anest
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
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 (For radical resection of tumor, soft tissue, use 27329)	$400.00	120	5.0+T

			Follow Up Days	Anest
INTRODUCTION OR REMOVAL				
27370	Injection procedure for knee arthrography (For radiological supervision and interpretation, see 73580)	$12.00		3.0+T
27372	Removal foreign body, deep, thigh region or knee area (For removal of knee prosthesis including "total knee", see 27488)	$120.00		3.0+T
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 (For arthroscopic repair, use 29882)	$200.00	90	3.0+T
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

			Follow Up Days	Anest
27425	Lateral retinacular release open (For arthroscopic lateral release, use 29873)	$225.00	120	3.0+T
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

			Follow Up Days	Anest
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
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	$200.00	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 withou external fixation, with insertion of intramedullary implant with or without cerclage and/or locking screws	$360.00	180	3.0+T

			Follow Up Days	Anest
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	$310.00	180	3.0+T
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

			Follow Up Days	Anest
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
27550	Closed treatment of knee dislocation; without anesthesia	$80.00	90	3.0+T
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		3.0+T
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)

			Follow Up Days	Anest
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

			Follow Up Days	Anest
	INTRODUCTION OR REMOVAL			
27648	Injection procedure for ankle arthrography (For radiological supervision and interpretation, see 73615; for ankle arthroscopy, see 29894-29898)	$12.00		3.0+T
	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) (Toe extensors are considered as a group to be a single tendon when transplanted into midfoot)	$120.00	90	3.0+T
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 code for 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
27698	Repair, secondary disrupted ligament,ankle, collateral (eg, Watson-Jones procedure)	$240.00	180	3.0+T

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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	
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

			Follow Up Days	Anest
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

			Follow Up Days	Anest
MISCELLANEOUS				
27892	Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve (For decompression fasciotomy of the leg without debridement, see 27600)	$135.00	90	3.0+T
27893	posterior compartment(s) only, with debridement of nonviable muscle and/or nerve (For decompression fasciotomy of the leg without debridement, see 27601)	$135.00	90	3.0+T
27894	anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve (For decompression fasciotomy of the leg without debridement, see 27602)	$165.00	90	3.0+T
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 (For open tenotomy, see 28230-28234)	$30.00		3.0+T
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) (For other nerve entrapments, see 64704, 64722)	$120.00	45	3.0+T

			Follow Up Days	Anest
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	
28111	Ostectomy, complete excision; first metatarsal head	$120.00	60	
28112	other metatarsal head (second, third or fourth)	$70.00	60	
28113	fifth metatarsal head	$20.00	60	
28114	all metatarsal heads, with partial proximal phyalangectomy, excluding first metatarsal (Clayton type procedure)	$200.00	60	

			Follow Up Days	Anest
28116	Ostectomy, excision of tarsal coalition	$120.00	90	
28118	Ostectomy, calcaneus;	$200.00	150	
28119	for spur, with or without plantar fascial release	$200.00	150	
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	$100.00	90	
28122	tarsal or metatarsal bone except talus or calcaneous	$100.00	90	
	(For partial excision of talus or calcaneus, use 28120) (For cheilectomy for hallux rigidus, use 28289)			
28124	phalanx of toe	$60.00	90	
28126	Resection, partial or complete, phalangeal base, each toe	$50.00	90	
28130	Talectomy (astragalectomy)	$220.00	120	
28140	Metatarsectomy	$100.00	60	
28150	Phalangectomy, toe, each toe	$60.00	60	
28153	Resection, condyle(s), distal end of phalanx, each toe	$45.00	60	
28160	Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each	$60.00	60	
28171	Radical resection of tumor, bone; tarsal (except talus or calcaneus)	BR	90	
28173	metatarsal	$160.00	90	
28175	phalanx of toe	$120.00	90	
	(For talus or calcaneus, see 27647)			
	INTRODUCTION OR REMOVAL			
28190	Remove foreign body, foot; subcutaneous	$8.00		
28192	deep	$16.00		
28193	complicated	$16.00		
	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
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

			Follow Up Days	Anest
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
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint	$188.00	90	3.0+T

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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 (see 20661-20663 for insertion)	$ 80.00	2	3.0+T
29010	Application of Risser jacket, localizer, body; only	$50.00	2	3.0+T
29015	including head	$60.00	2	3.0+T
29020	Application of turnbuckle jacket, body; only	$50.00	2	3.0+T
29025	including head	$60.00	2	3.0+T

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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 (For open procedure, use 21010)	$225.00	90	3.0+T
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure) (For open procedure, see 23065-23066, 23100-23101)	$107.00	90	3.0+T
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy (For open procedure, see 23450-23466) (To report thermal capsulorrhaphy, use 29999)	$297.00	90	3.0+T
29807	repair of slap lesion	$290.00	90	3.0+T
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body (For open procedure, see 23040-23044, 23107)	$225.00	90	3.0+T
29820	synovectomy, partial	$305.00	120	3.0+T
29821	synovectomy, complete (For 29820 and 29826, for open procedure, see 23105)	$305.00	120	3.0+T
29822	debridement, limited	$225.00	90	3.0+T
29823	debridement, extensive	$225.00	90	3.0+T

			Follow Up Days	Anest
29824	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	$260.00	90	3.0+T
	(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)			
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

			Follow Up Days	Anest
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 (For open lateral release, use 27425)	$225.00	90	3.0+T
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

			Follow Up Days	Anest
29882	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	$129.00	90	3.0+T
	(Do not report 29900 with 29901, 29902)			
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

RESPIRATORY SYSTEM

NOSE

INCISION

(For lateral rhinotomy, see specific application, eg, 30118, 30320)

			Follow Up Days	Anest
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

(Procedure 30110 would normally be completed in an office setting. Procedure 30115 would normally require the facilities available in a hospital setting.)

30100	Biopsy, intranasal (For biopsy skin of nose, see 11100, 11101)	$12.00	7	3.0+T
30110	Excision, nasal polyp(s), simple	$28.00	15	3.0+T
30115	Excision, nasal polyp(s), extensive	$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 turbinate, partial or complete, any method	$60.00	90	3.0+T
30140	Submucous resection turbinate, partial or complete, any method (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 (For closure and/or reconstruction, primary or delayed, see Integumentary System, 13150-13160, 14060-14300, 15120, 15121, 15260, 15261, 15760, 20900-20912)	$80.00	90	3.0+T

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

			Follow Up Days	Anest
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 excludes obtaining graft. For graft procedure, see 20900-20926, 21210) (30465 is used to report a bilateral procedure)	$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
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

			Follow Up Days	Anest
DESTRUCTION				
30801	Cautery and/or ablation, mucosa of 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 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
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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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
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)			

			Follow Up Days	Anest
31420	Epiglottidectomy	$240.00	365	6.0+T
	INTRODUCTION			
31500	Intubation, endotracheal, emergency procedure (For injection procedure for bronchography, see 31656, 31708, 31710)	$20.00		4.0+T
	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	$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	$160.00	30	4.0+T
31535	Laryngoscopy, direct, operative, with biopsy;	$60.00	30	4.0+T
31536	with operating microscope	$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	$160.00	30	4.0+T
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	$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	$120.00	7	4.0+T

			Follow Up Days	Anest
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
31585	Treatment of closed laryngeal fracture; without manipulation	$130.00	180	6.0+T
31586	with closed manipulative reduction	$210.00	180	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
	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)			

			Follow Up Days	Anest
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 code for 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
31631	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 code for primary procedure)	$21.00		
31633	with transbronchial needle aspiration biopsy(s), each additional lobe (list separately in addition to code for 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

			Follow Up Days	Anest
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)			

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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
32020	Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure) (If imaging guidance is performed, use 75989)	$20.00		3.0+T
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)			
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

			Follow Up Days	Anest
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
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		
32520	Resection of lung; with resection of chest wall	$600.00	180	11.0+T
32522	with reconstruction of chest wall, without prosthesis	$650.00	180	11.0+T
32525	with major reconstruction of chest wall, with prosthesis	$700.00	180	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

			Follow Up Days	Anest
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
32661	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

			Follow Up Days	Anest
	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

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

			Follow Up Days	Anest
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 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.

(For electronic, telephonic analysis of pacemaker system, see 93731-93736; for radiological supervision and interpretation with insertion of pacemaker see 71090)

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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
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)	$127.00	90	3.0+T
	(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)			
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

			Follow Up Days	Anest
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)			
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 systen (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

			Follow Up Days	Anest
PATIENT-ACTIVATED EVENT RECORDER				
33282	Implantation of patient-activated cardiac event recorder (Initial implantation includes programming. For subsequent electronic analysis and/or reprogramming, use 93727)	$108.00	90	3.0+T
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
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 (Do not report modifier –63 in conjunction with 33401, 33403)	BR	90	15.0+T
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

			Follow Up Days	Anest
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
	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

			Follow Up Days	Anest
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

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; 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

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.

			Follow Up Days	Anest
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

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

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.

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
	TOTAL ANOMALOUS PULMONARY VENOUS DRAINAGE			
	(Do not report modifier –63 in conjunction with 33730, 33732)			
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	$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
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
	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

			Follow Up Days	Anest
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 (For pulmonary artery band, see 33690)	$650.00	90	15.0+T
	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

			Follow Up Days	Anest
33877	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	$950.00	90	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
33918	Repair of pulmonary atresia with ventricular septal defect, by unifocalization of pulmonary arteries; without cardiopulmonary bypass	BR	90	15.0+T
33919	with cardiopulmonary bypass	$665.00	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 (For repair of other complex cardiac anomalies by construction or replacement of right or left ventricle to pulmonary artery conduit, see 33608)	$625.00	90	15.0+T
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		
	MISCELLANEOUS			
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

			Follow Up Days	Anest
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
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.

ENDOVASCULAR REPAIR OF ABDOMINAL AORTIC ANEURYSM

34001	Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision	$240.00	60	6.0+T

			Follow Up Days	Anest
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
	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).

			Follow Up Days	Anest
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	$65.00	90	15.0+T
	(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)			
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
34813	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair	$75.00	90	15.0+T
	(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)			
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	$65.00	90	

			Follow Up Days	Anest
	(List separately in addition to primary procedure) (Use 34826 in conjunction with code 34825) (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 infrarenal 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 infrarenal 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.

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).

			Follow Up Days	Anest
34900	Endovascular graft replacement for repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) (For radiological supervision and interpretation, use 75954) (For placement of extension prothesis during endovascular iliac artery repair, use 34825) (For bilateral procedure, use modifier –50)	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		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
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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
	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
	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

			Follow Up Days	Anest
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, OPEN

(For radiological supervision and interpretation, see 75962-75968, 75978)

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)

TRANSLUMINAL ANGIOPLASTY, 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

			Follow Up Days	Anest
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, OPEN

(For radiological supervision and interpretation, see 75992-75996)

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

TRANSLUMINAL ATHERECTOMY, 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

BYPASS GRAFT VEIN

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

			Follow Up Days	Anest
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
35566	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	

			Follow Up Days	Anest
BYPASS GRAFT - 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
BYPASS GRAFT 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
35651	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

			Follow Up Days	Anest

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.

List 35681-35683 separately in addition to code for primary procedure. Do not report 35681-35683 in addition to each other.

35681	Bypass graft; composite, prosthetic and vein	$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	$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	$64.00
	(List separately in addition to primary procedure)	
	(Use 35685 in conjunction with codes 35656, 35666, or 35671)	
35686	Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis)	$53.00
	(List separately in addition to primary procedure) (Use 35686 in conjunction with codes 35556, 35566, 35571, 35583-35587, 35623, 35656, 35666, 35671)	

			Follow Up Days	Anest
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)

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.

			Follow Up Days	Anest
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
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) (For radiological supervision and interpretation, use 75820, 75822)	$20.00	3.0+T

			Follow Up Days	Anest
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
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.

			Follow Up Days	Anest
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		3.0+T
36261	Revision of implanted intra-arterial infusion pump	$100.00		3.0+T
36262	Removal of implanted intra-arterial infusion pump	$75.00		3.0+T
36299	Unlisted procedure, vascular injection (Use in addition to 36246 or 36247 as appropriate)	BR		3.0+T

VENOUS

(Do not report modifier –63 in conjunction with 36415, 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

			Follow Up Days	Anest
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		
36522	Photopheresis, extracorporeal	$150.00		3.0+T
	(For professional component, see modifier -26)			
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

			Follow Up Days	Anest
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
	INTRAOSSEOUS			
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
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

			Follow Up Days	Anest
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
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	$32.00		3.0+T
	(See also 96420-96425) (For arterial catheterization for occlusion therapy, see 75894)			

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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) (For percutaneous procedure, see 37182)	$400.00	90	9.0+T
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

			Anest
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.			
37195	Thrombolysis, cerebral, by intravenous infusion	$90.00	
37200	Transcatheter biopsy (For radiological supervision and interpretation, see 75970)	$70.00	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) (For 37201, 37202, for radiological supervision and interpretation, use 75896) (For thromolysis of coronary vessels, see 92975, 92977)	$105.00	3.0+T
37203	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter) (For radiological supervision and interpretation, see 75961)	$90.00	3.0+T
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) (For radiological supervision and interpretation, see 75894)	$300.00	3.0+T
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 arterial catheter during thrombolytic therapy (For radiological supervision and interpretation, see 75900)	$40.00	3.0+T

			Follow Up Days	Anest
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) (For open procedure, use 37760)	$216.00		3.0+T
37501	Unlisted vascular endoscopy procedure	BR		3.0+T

LIGATION AND OTHER PROCEDURES

(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

			Follow Up Days	Anest
37620	Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular,intravascular (umbrella device) (For radiological supervision and interpretation, see 75940)	$240.00	90	5.0+T
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
37720	Ligation and division and complete stripping of long OR short saphenous veins	$120.00	30	3.0+T
37730	Ligation and division and complete stripping of long AND short saphenous veins	$160.00	30	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
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
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

			Follow Up Days	Anest
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
GENERAL				
INTRODUCTION				
38200	Injection procedure for splenoportography (For radiological supervision and interpretation, see 75810)	$40.00	7	3.0+T
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 (If imaging guidance is performed, see 76360, 76393, 76942) (For fine needle aspiration, use 10021 or 10022)	$20.00		3.0+T
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)	$20.00	30	3.0+T

			Follow Up Days	Anest
	(If imaging guidance is performed, see 76360, 76393, 76942)			
	(For fine needle aspiration, use 10021, 10022)			
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)	$120.00	30	3.0+T
	(Do not report 38530 with 38720-38746)			
	(For percutaneous needle biopsy, retroperitoneal lymph node or mass, see 49180; for fine needle aspiration, use 10022)			
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 (SEPARATE PROCEDURE)			
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 retronperitoneal lymphadenectomies, see 38562, 38564)

			Follow Up Days	Anest
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		
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

			Follow Up Days	Anest
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)			

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

DIGESTIVE SYSTEM

LIPS

(For procedures on skin of lips, see 10060 et seq)

EXCISION

			Follow Up Days	Anest
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 (For excision of mucous lesions, see 40810-40816)	$100.00	120	3.0+T
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 (For reconstruction, see 13131 et seq)	$100.00	120	3.0+T

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

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

			Follow Up Days	Anest
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	$120.00	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) (For skin grafts, see 15000 et seq)	$260.00	30	3.0+T
40899	Unlisted procedure, vestibule of mouth	BR		3.0+T

TONGUE, 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

			Follow Up Days	Anest
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	BR		
	(List in addition to code 41112, 41113)			
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
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

			Follow Up Days	Anest
	MISCELLANEOUS			
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) (For frenotomy, see 40806, 41010)	$75.00	30	3.0+T
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
	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

			Follow Up Days	Anest
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 (For reconstruction of palate with extraoral tissue, See 14040-14300,15050, 15120, 15240, 15576)	$160.00	90	6.0+T
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
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 (For repair of cleft lip, see 40700 et seq)	$80.00	30	3.0+T
42299	Unlisted procedure, palate, uvula	BR		3.0+T

SALIVARY GLANDS AND DUCTS

INCISION

			Follow Up Days	Anest
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
42325	Fistulization of sublingual salivary cyst (ranula);	$60.00	30	3.0+T
42326	with prosthesis	BR		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	$100.00	30	3.0+T

EXCISION

42400	Biopsy of salivary gland; needle (For fine needle aspiration, see 10021, 10022)	$20.00	30	3.0+T
42405	incisional (If imaging guidance is performed, see 76003, 76360, 76393, 76942)	$20.00	30	3.0+T
42408	Excision of sublingual salivary cyst (ranula)	$60.00	30	3.0+T
42409	Marsupialization of sublingual salivary cyst (ranula) (For fistulization of sublingual salivary cyst, see 42325)	$60.00	30	3.0+T
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 (For suture or grafting of facial nerve, see 64864, 64865, 69740, 69745)	$440.00	60	3.0+T
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

			Follow Up Days	Anest
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
	MISCELLANEOUS			
42550	Injection procedure for sialography (For radiological supervision and interpretation, see 70390)	$4.00		3.0+T
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)			
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

			Follow Up Days	Anest
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) (For pharyngeal flap, use 42225)	$240.00	90	6.0+T
42953	Pharyngoesophageal repair (For closure with myocutaneous or other flap, use appropriate number in addition)	$240.00	90	12.0+T

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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
	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

			Follow Up Days	Anest
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 intramural or transmural fine needle aspiration/biopsy(s)	$80.00	15	4.0+T
	(Do not report 76975 in conjunction with 43231, 4323			
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

			Follow Up Days	Anest
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)	$100.00	7	4.0+T
	(Do not report 76975 in conjunction with 43242)			
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)	$140.00	7	4.0+T
	(Do not report 43245 in conjunction with 43256)			
43246	with directed placement of percutaneous gastrostomy tube	$240.00	45	5.0+T
	(For radiological supervision and interpretation, see 74350)			
43247	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

			Follow Up Days	Anest
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	$270.00	7	4.0+T
43268	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.

			Follow Up Days	Anest
43280	Laparascopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures) (For open approach, use 43324)	$320.00	90	4.0+T
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 (Do not report modifier –63 in conjunction with 43313, 43314)	BR	90	11.0+T
43320	Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach	$320.00	90	12.0+T
43324	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures) (For laparoscopic procedure, use 43280)	$320.00	90	12.0+T
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure) (For cricopharyngeal myotomy, see 43030)	$320.00	90	12.0+T
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 (For thoracoscopic esophagomyotomy, use 32665)	$320.00	90	12.0+T
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

			Follow Up Days	Anest
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)			
	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	$600.00	90	6.0+T
	(Do not report 43496 in addition to code 69990)			
43499	Unlisted procedure, esophagus	BR		3.0+T

			Follow Up Days	Anest
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
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
43638	Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy;	$320.00	60	6.0+T
43639	with pyloroplasty or pyloromyotomy	$393.00	90	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.

			Follow Up Days	Anest
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

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

OTHER PROCEDURES

43800	Pyloroplasty (For pyloroplasty and vagotomy, see 43640)	$200.00	45	5.0+T
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

			Follow Up Days	Anest
43832	with construction of gastric tube (eg, Janeway procedure)	$160.00	45	5.0+T
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 of gastric restrictive procedure for morbid obesity (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
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
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

			Follow Up Days	Anest
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; do not report modifier –63 in conjunction with 44126, 44127, 44128)	$72.00		
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
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		

			Follow Up Days	Anest
44140	Colectomy, partial; with anastomosis (For laparoscopic procedure, use 44204)	$320.00	90	5.0+T
44141	with skin level cecostomy or colostomy	$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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

44200	Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion)(separate procedure) (For laparoscopy with salpingolysis, ovariolysis, use 58660)	$251.00	90	6.0+T

			Follow Up Days	Anest
44201	jejunostomy (eg, for decompression or feeding)	$172.00	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
44211	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
44238	Unlisted laparoscopy procedure, intestine (except rectum)	BR	90	6.0+T
44239	Unlisted laparoscopy procedure, rectum	BR	90	6.0+T

ENTEROSTOMY - EXTERNAL FISTULIZATION OF INTESTINES

			Follow Up Days	Anest
44300	Enterostomy, or cecostomy, tube (eg, for decompression or feeding) (separate procedure)	$170.00	90	4.0+T
44310	Ileostomy or jejunostomy, non-tube (separate procedure) (Do not report 44310 in addition to 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; (separate procedure)	$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

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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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 (For unlisted laparoscopic procedure, intestine except rectum, use 44238)	BR		5.0+T

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) (For excision with bowel resection, see 44120 or 44140 et seq)	$200.00	45	4.0+T

SUTURE

44850	Suture of mesentery (separate procedure) (For reduction and repair of internal hernia, see 44050)	$160.00	45	4.0+T
44899	Unlisted procedure, Meckel's diverticulum	BR		4.0+T

APPENDIX

INCISION

44900	Incision and drainage of appendiceal abscess, open	$120.00	45	4.0+T
44901	percutaneous (For radiological supervision and interpretation, use 75989)	$86.00	45	4.0+T

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

			Follow Up Days	Anest
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) (For endoscopic biopsy, see 45305)	$20.00	15	3.0+T
45108	Anorectal myomectomy	$160.00	90	3.0+T
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 or without proximal diverting ostomy	$450.00	90	7.0+T

			Follow Up Days	Anest
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

DESTRUCTION

45190	Destruction of rectal tumor, (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach	$151.00	90	4.0+T

ENDOSCOPY

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)

			Follow Up Days	Anest
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) (For radiological supervision and interpretation, use 74360)	$20.00	15	3.0+T
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
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

			Follow Up Days	Anest
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) (Do not report 76975 in conjunction with codes 45341, 45342) (For transrectal ultrasound utilizing rigid probe device, use 76872)	$65.00	15	3.0+T
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
45383	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 (For small bowel and stomal endoscopy, see 44360-44393)	$140.00	15	4.0+T
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

			Follow Up Days	Anest
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 for prolapse; abdominal approach	$240.00	90	5.0+T
45541	perineal approach	$240.00	90	5.0+T
45550	Proctopexy combined 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)			
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	$67.00	10	3.0+T
	(Do not report in addition to 46060, 46280, 46600)			
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

			Follow Up Days	Anest
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) (For anoplasty, see 46700-46705)	$20.00	30	3.0+T
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

			Follow Up Days	Anest
INTRODUCTION				
46500	Injection of sclerosing solution, hemorrhoids	$8.00		3.0+T
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
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

			Follow Up Days	Anest
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 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

			Follow Up Days	Anest
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
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

LAPAROSCOPY

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (Peritoneoscopy)(separate procedure), use 49320.

			Follow Up Days	Anest
47370	Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency	$280.00	90	3.0+T
	(For imaging guidance, use 76490)			
47371	cryosurgical	$264.00	90	3.0+T
	(For imaging guidance, use 76490)			
47379	Unlisted laparoscopic procedure, liver	BR		3.0+T

OTHER PROCEDURES

47380	Ablation, open, of one or more liver tumor(s); radiofrequency	$329.00	90	6.0+T
	(For imaging guidance, use 76490)			
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)			

			Follow Up Days	Anest
INTRODUCTION				
47500	Injection procedure for percutaneous transhepatic cholangiography	$40.00	7	3.0+T
	(For radiological supervision and interpretation, see 74320)			
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	$114.00	90	3.0+T
	(For radiological supervision and interpretation, see 75980)			
47511	Introduction of percutaneous transhepatic stent for internal and external biliary drainage	$142.00	90	3.0+T
	(For radiological supervision and interpretation, see 75982)			
47525	Change of percutaneous biliary drainage catheter	$78.00	10	3.0+T
	(For radiological supervision and interpretation, see 75984)			
47530	Revision and/or reinsertion of transhepatic tube	$77.00	90	3.0+T
	(For radiological supervision and interpretation, see 75984)			
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)			
LAPAROSCOPY				
	Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.			

			Follow Up Days	Anest
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 (For laparoscopic approach, see 47562-47564)	$270.00	45	5.0+T
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) (For radiological supervision and interpretation, see 74327)	$60.00	7	3.0+T
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) (Do not report modifier –63 in conjunction with 47700, 47701)	$391.00	90	7.0+T
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
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

			Follow Up Days	Anest
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)			
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

			Follow Up Days	Anest
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

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 (To report re-exploration of hepatic wound for removal of packing, use 47362)	$160.00	45	4.0+T

			Follow Up Days	Anest
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	$159.00	45	4.0+T
	(For radiological supervision and interpretation, use 75989)			
49040	Drainage of subdiaphragmatic or subphrenic abscess; open	$200.00	45	5.0+T
49041	percutaneous	$104.00		5.0+T
	(For radiological supervision and interpretation, use 75989)			
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)			
	EXCISION, DESTRUCTION			
49180	Biopsy, abdominal or retroperitoneal mass, percutaneous needle	$40.00	10	3.0+T
	(If imaging guidance is performed, see 76003, 76360, 76393, 76942)			
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	$425.00	60	5.0+T
	(Do not report modifier –63 in conjunction with 49215)			

			Follow Up Days	Anest
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)	$16.00		3.0+T
	(For radiological supervision and interpretation, see 74190)			
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

			Follow Up Days	Anest
49422	Removal of permanent intraperitoneal cannula or catheter (For removal of a temporary catheter/cannula, use appropriate E/M code)	$116.00	21	3.0+T
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 (For shunt patency test, see 78291)	$161.00	45	5.0+T
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.

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)

			Follow Up Days	Anest
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
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	$87.00		
	(List separately in addition to code for the incisional or ventral hernia repair)			

			Follow Up Days	Anest
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	$150.00	45	3.0+T
	(Do not report modifier –63 in conjunction with 49600-49611)			
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

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

			Follow Up Days	Anest
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 (For laparoscopic ablation of renal mass lesion(s), use 50542)	$260.00	90	5.0+T
50020	Drainage of perirenal or renal abscess; open	$200.00	90	5.0+T
50021	percutaneous (For radiological supervision and interpretation, use 75989)	$140.00		5.0+T
50040	Nephrostomy, nephrotomy with drainage	$320.00	90	5.0+T
50045	Nephrotomy, with exploration (For renal endoscopy performed with nephrotomy, see 50570-50580)	$320.00	90	5.0+T
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
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)			

			Follow Up Days	Anest
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 (For fine needle aspiration, use 10022) (For radiological supervision and interpretation, see 76003, 76360, 76393, 76942)	$20.00		3.0+T
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 (When vena caval resection with reconstruction is necessary use 37799)	$390.00	90	5.0+T
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 (For laparoscopic partial nephrectomy, use 50543)	$400.00	90	5.0+T
50280	Excision or unroofing of cyst(s)of kidney (For laparoscopic ablation of renal cysts, use 50541)	$280.00	90	5.0+T
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)

			Follow Up Days	Anest
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

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
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

			Follow Up Days	Anest
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 fluoroscopic guidance, see 76000; for radiological supervision and interpretation, see 75984)	$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
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

			Follow Up Days	Anest
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 (For laparoscopic drainage of lymphocele to peritoneal cavity, use 49323)	BR		5.0+T
	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 (When procedures 50570-50580 provide a significant identifiable service, they may be added to 50045 and 50120)	$170.00	7	3.0+T
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

			Follow Up Days	Anest
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	$233.00		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)			

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

			Follow Up Days	Anest
50688	Change of ureterostomy tube (If imaging guidance is performed, use 75984)	$4.00		3.0+T
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 reter (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 (Codes 50780-50785 include minor procedures to prevent vesicoureteral reflux)	$320.00	90	5.0+T
50780	Ureteroneocystostomy; anastomosis of single ureter to bladder (When combined with cystourethroplasty or vesical neck revision, see 51820)	$356.00	90	5.0+T
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) (For combination of 50800-50820 with cystectomy, see 51580-51595)	$455.00	90	5.0+T

			Follow Up Days	Anest
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 (For ureteroplasty, ureteroylysis, see 50700-50860)	$300.00	90	5.0+T

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)			

			Follow Up Days	Anest
50970	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; (For ureterotomy, use 50600)	$17.00	7	3.0+T
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

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 (If imaging guidance is performed, see 76003, 76360, 76942)	$40.00	30	3.0+T
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

			Follow Up Days	Anest
51530	for excision of bladder tumor (For transurethral resection, see 52234-52240, 52305; excision, see 52300)	$240.00	90 for transurethra	5.0+T
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
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 (For pelvic exenteration for gynecologic malignancy, use 58240)	$800.00	90	15.0+T

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

			Anest
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 no 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 (If imaging guidance is performed, use 75984)	$30.00	3.0+T
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	$72.00	3.0+T
L8603	Collagen implant, urinary tract, per 2.5 cc syringe	BR	
51720	Bladder instillation of anticarcinogenic agent (including detention time)	$4.00	3.0+T

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

			Follow Up Days	Anest
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
51840	Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz, Burch); simple	$160.00	45	4.0+T
51841	complicated (eg, secondary repair) (For urethropexy (Pereyra type), see 57289)	$275.00	45	4.0+T
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 (For closure of vesicovaginal fistula, vaginal approach, see 57320-57330)	$240.00	90	5.0+T
51920	Closure of vesicouterine fistula;	$240.00	90	5.0+T
51925	with hysterectomy (See Rule 14) (For closure of vesicoenteric fistula, see 44660, 44661; for closure of rectovesical fistula, see 45800-45805)	$360.00	90	5.0+T
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) (For open sling operation for stress incontinence, use 57288) (For reversal or removal of sling operation for stress incontinence, use 57287)	$151.00	90	5.0+T

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.

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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.

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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	Non-contact laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystoure-throscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	$220.00	90	5.0+T
52648	Contact laser vaporization with or without transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystoure-throscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	$233.00	90	5.0+T
52700	Transurethral drainage of prostatic abscess	$120.00	60	

URETHRA

(For endoscopy, see cystoscopy, urethroscopy, cystourethroscopy,52000-52700)
(For injection procedure for urethrocystography, see 51600-51610)

			Follow Up Days	Anest
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

			Follow Up Days	Anest
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
53502	Urethrorrhaphy, suture of urethral wound or injury; female	BR	60	4.0+T
53505	penile	$150.00	60	4.0+T

			Follow Up Days	Anest
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) (For closure of urethrovaginal fistula, see 57310; for closure of urethrorectal fistula, see 45820, 45825)	$120.00	60	4.0+T

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
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 (For skin and subcutaneous abscess, see 10060-10160)	$12.00		3.0+T

			Follow Up Days	Anest
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	$12.00	15	3.0+T
	(Do not report modifier -63 in conjunction with 54150)			
54152	except newborn	$20.00	15	3.0+T
54160	Circumcision, surgical excision other than clamp, device or dorsal slit; newborn	$40.00	30	3.0+T
	(Do not report modifier -63 in conjunction with 54160)			
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	$54.00	30	3.0+T
	(Do not report with circumcision codes 54150-54161, 54162, 54163)			

			Follow Up Days	Anest
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	$5.00		3.0+T
	(For radiological supervision and interpretation, see 74445)			
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
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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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
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 (For orchiectomy with repair of hernia, see 49505 or 49507 and 54520) (For radical retroperitoneal lymphadenectomy, see 38780)	$280.00	90	3.0+T

			Follow Up Days	Anest
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 (For inguinal hernia repair performed in conjunction with inguinal orchiopexy, see 49495-49525)	$200.00	60	3.0+T
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
	EXCISION			
54800	Biopsy of epididymis, needle (For fine needle aspiration, see 10021, 10022)	$8.00	15	3.0+T
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

			Follow Up Days	Anest
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

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

			Follow Up Days	Anest
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
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 (For injection procedure, see 52010, 55300)	$320.00	90	3.0+T
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 (For transurethral drainage, see 52700)	$210.00	60	4.0+T

			Follow Up Days	Anest
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)			
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

			Follow Up Days	Anest
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 (For open procedure, use 55840) (For application of interstitial radioelement, see 77776-77778) (For ultrasonic guidance for interstitial radioelement application, see 76965)	$400.00	90	6.0+T
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

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

			Follow Up Days	Anest
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)			
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 (For lymphadenectomy, see 38760-38780)	$477.00	90	5.0+T
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)			

			Follow Up Days	Anest
	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)			
	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

			Follow Up Days	Anest
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
	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 (For insertion of radioelement sources or ribbons, see 77761-77763, 77781-77784)	$114.00	90	3.0+T
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	$140.00	60	3.0+T

			Follow Up Days	Anest
	(For repair of rectocele (separate procedure) without posterior colporrhapy, see 45560)			
57260	Combined anteroposterior colporrhaphy;	$200.00	60	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 code for 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
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
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)			

			Follow Up Days	Anest
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 (For removal without anesthesia of an impacted vaginal foreign body, use the appropriate Evaluation and Management code)	$14.00	10	3.0+T
ENDOSCOPY				
57420	Colposcopy of the entire vagina, with cervix if present;	$36.00		3.0+T
57421	with biopsy(s) (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)	$40.00		3.0+T
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

			Follow Up Days	Anest
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
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)			
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

			Follow Up Days	Anest
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) (For codes 58150-58285, see Rule 14)	$200.00	45	4.0+T
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) (For urethrocystopexy without hysterectomy, see 51840, 51841)	$320.00	45	4.0+T
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

			Follow Up Days	Anest
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, A4260)

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

			Follow Up Days	Anest
58520	Hysterorrhaphy, repair of ruptured uterus (nonobstetrical)	$160.00	45	4.0+T
58540	Hysteroplasty, repair of uterine anomaly (Strassman type) (For closure of vesicouterine fistula, see 51920)	BR	45	4.0+T

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
58578	Unlisted laparoscopy procedure, uterus	BR		3.0+T
58579	Unlisted hysteroscopy procedure, uterus	BR		3.0+T

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

			Follow Up Days	Anest
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
	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

			Follow Up Days	Anest
REPAIR				
58740	Lysis of adhesions (salpingolysis, ovariolysis) (For laparascopic approach, see 58660; for excision/destruction of endometriomas, open method, see 49200, 49201; for fulguration or excision of lesions, laparascopic approach, see 58662)	$417.00	45	4.0+T
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
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

			Follow Up Days	Anest
58950	Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy;	$290.00	60	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

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)

			Follow Up Days	Anest

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
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

			Follow Up Days	Anest
	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
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.			

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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
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 (For thyroid ultrasonography, see 76536)	$180.00	45	4.0+T

PARATHYROID, THYMUS, ADRENAL GLANDS AND CARTOID BODY

EXCISION

(For excision of remote/disseminated pheochromocytoma, see 49200-49201)

			Follow Up Days	Anest
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)	$79.00	45	5.0+T
	(Use 60512 in conjunction with codes 60500, 60502, 60505, 60212, 60225, 60240, 60252, 60254, 60260, 60270, 60271)			
60520	Thymectomy, partial or total; transcervical approach (separate procedure)	$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
60545	with excision of adjacent retroperitoneal tumor	$400.00	90	9.0+T
	(For excision of remote or disseminated pheochromocytoma, see 49200, 49201) (For laparoscopic approach, use 56321)			
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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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
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	$26.00		9.0+T
	(List separately in addition to primary procedure)			
	(Use 61316 in conjunction with codes 61304, 61312, 61313, 61322, 61323, 61340, 61570, 61571, 61680-61705)			
61320	Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial	$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 (Do not report 61313 in addition to 61322, 61323, for subtemporal decompression, use 61340)	$538.00	60	9.0+T
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

			Follow Up Days	Anest
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
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

			Follow Up Days	Anest
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	$410.00	90	9.0+T
	(For stereotactic implantation of electrodes, see 61760)			
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

			Follow Up Days	Anest
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
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) (For arthrodesis, use 22548)	$800.00	90	9.0+T

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.

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 TO ANTERIOR CRANIAL FOSSA

			Follow Up Days	Anest
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

APPROACH TO MIDDLE CRANIAL FOSSA

			Follow Up Days	Anest
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
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
	APPROACH TO 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 OF 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

DEFINITIVE PROCEDURES OF BASE OF MIDDLE CRANIAL FOSSA

			Follow Up Days	Anest
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

DEFINITIVE PROCEDURES OF 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

			Follow Up Days	Anest
	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)	$249.00		3.0+T
	(See also 37204)			
	(For radiological supervision and interpretation, see 75894)			
	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)			

			Follow Up Days	Anest
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) (For cervical approach for direct ligation of carotid artery, see 37600-37606)	$350.00	90	11.0+T
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 (For ligation or gradual occlusion of internal/common carotid artery, see 37605, 37606)	$350.00	90	11.0+T
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 (For carotid or vertebral thromboendarterectomy, see 35301)	$800.00	90	15.0+T
	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 (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)	$370.00	90	11.0+T
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

			Follow Up Days	Anest
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		
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)

			Follow Up Days	Anest
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 (For repair of spinal dural/CSF leak, see 63707 or 63709)	$400.00	60	9.0+T
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
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

			Follow Up Days	Anest
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

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
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.

(For daily hospital management of continuous epidural or subarachnoid drug administration performed in conjunction with codes 62318-62319, see Evaluation and Management Services.

			Follow Up Days	Anest
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) (62263 and 62264 include codes 76005 and 72275)	$173.00	7	3.0+T
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) (For fine needle aspiration, see 10021, 10022)	$80.00	7	3.0+T
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

			Follow Up Days	Anest
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) (For injection procedure at C1-C2, see 61055)	$40.00	7	3.0+T
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) (For fluoroscopic guidance, use 76003)	$150.00	7	3.0+T
62290	Injection procedure for diskography, each level; lumbar	$40.00	7	3.0+T
62291	cervical or thoracic	$40.00	7	3.0+T
	(For radiological supervision and interpretation, see 72285, 72295)			
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)			

			Follow Up Days	Anest
	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
	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, 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

			Follow Up Days	Anest
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
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 (use 63035 in conjunction with codes 63020-63030) (List separately in addition to code for primary procedure)	$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		

			Follow Up Days	Anest
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	$70.00		
	(Use 63048 in conjunction with codes 63045-63047)			
	(List separately in addition to primary procedure)			
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
	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	$100.00	90	
	(List separately in addition to primary procedure)			
	(Use 63057 in conjunction with codes 63055, 63056)			
63064	Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic; single segment	$360.00	90	7.0+T
63066	each additional segment	$65.00	90	
	(List separately in addition to primary procedure)			
	(Use 63066 in conjunction with code 63064)			
	(For excision of thoracic intraspinal lesions by laminectomy, see 63266, 63271, 63276, 63281 and 63286)			

			Follow Up Days	Anest
	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) (Do not report code 69990 in addition to codes 63075-63078)	$80.00		
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) (For transoral approach, see 61575-61576)	$90.00	90	
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	$60.00	90	

			Follow Up Days	Anest
	(Use 63091 in conjunction with code 63090) (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
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 (For resection of sternocleidomastoid muscle, use 21720)	$400.00	90	7.0+T
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

			Follow Up Days	Anest
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
63286	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) (For drainage of intramedullary cyst/syrinx, use 63172, 63173)	$91.00		7.0+T

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

			Follow Up Days	Anest
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.

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)

			Follow Up Days	Anest
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 (For complex skin closure, see Integumentary System) (For laminectomy and section of dentate ligaments, with or without dural graft cervical, see 63180-63182)	$280.00	90	9.0+T

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
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

			Follow Up Days
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

(For subarachnoid or subdural, injection, see 62280, 62310-62319, and for phenol destruction, see 64622-64627)
(Codes 64470-64484 are unilateral procedures. For bilateral procedures, use modifier -50)
(For epidural or caudal injection, see 62273, 62281-62282, 62310-62319)
(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	$10.00	
	(List separately in addition to primary procedure) (Use code 64472 in conjunction with code 64470)		
64475	lumbar or sacral, single level	$20.00	7
64476	lumbar or sacral, each additional level	$10.00	
	(List separately in addition to primary procedure) (Use code 64476 in conjunction with code 64475)		

			Follow Up Days	Anest
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	

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 (For open placement of cranial nerve (eg, vagal, trigeminal) neurostimulator pulse generator or receiver, see 61885, 61886, as appropriate)	$125.00	45	3.0+T
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

			Follow Up Days	Anest
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, RADIOFREQUENCY 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
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)	$40.00	15	3.0+T
64613	cervical spinal muscles (eg, for spasmodic torticollis)	$40.00	15	3.0+T
	(For chemodenervation for strabismus involving the extraocular muscles, see 67345)			
64614	extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)	$40.00	15	3.0+T
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	$20.00	7	3.0+T
	(List separately in addition to primary procedure)			
	(Use 64623 in conjunction with code 64622)			
64626	cervical or thoracic, single level	$20.00	7	3.0+T
64627	cervical or thoracic, each additional level	$10.00		
	(List separately in addition to primary procedure)			

			Follow Up Days	Anest
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
	DESTRUCTION BY NEUROLYTIC AGENT: SYMPATHETIC NERVES			
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	
	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 OF NERVE			
	(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

			Follow Up Days	Anest
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
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 (For excision of tender scar, skin and subcutaneous tissue, with or without tiny neuroma, see 11400-11446, 13100-13153)	$160.00	60	3.0+T

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

			Follow Up Days	Anest
64788	Excision of neurofibroma or neurolemmoma; cutaneous nerve	$32.00	60	3.0+T
64790	major peripheral nerve	$100.00	60	3.0+T
64792	extensive (including malignant type)	$160.00	60	3.0+T
64795	Biopsy of nerve	$20.00	15	3.0+T
	EXCISION - SYMPATHETIC NERVES			
64802	Sympathectomy, cervical	$240.00	60	6.0+T
64804	Sympathectomy, cervicothoracic	$280.00	60	6.0+T
64809	Sympathectomy, thoracolumbar	$260.00	60	5.0+T
64818	Sympathectomy, lumbar	$220.00	60	4.0+T
64820	Sympathectomy; digital arteries, each digit	$183.00	60	3.0+T
	(Do not report 69990 in addition to code 64820, 64821, 64822, 64823)			
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		

			Follow Up Days	Anest
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
	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

			Follow Up Days	Anest
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)			
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 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)			

			Follow Up Days	Anest
	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)			
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

			Follow Up Days	Anest
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
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

MISCELLANEOUS

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

			Follow Up Days	Anest
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
MISCELLANEOUS				
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 (For laser surgery, use 66821)	$200.00	45	4.0+T
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

			Follow Up Days	Anest
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 (For removal of implanted shunt, use 67120)	$180.00	90	8.0+T
REPAIR OR REVISION				
	(For scleral procedures in retinal surgery, see 67101 et seq; for scleral reinforcement, see 67250, 67255)			
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 (For unlisted procedure on anterior sclera, see 66999)	$120.00	30	6.0+T
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 (For iridotomy by photocoagulation, see 66761)	$80.00	30	4.0+T

			Follow Up Days	Anest
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
	(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

			Follow Up Days	Anest
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
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)

			Follow Up Days	Anest
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	$24.00		
	(List separately in addition to primary procedure)			
	(66990 may be used only with codes 65820, 65875, 65920, 66985, 66986, 67038, 67039, 67040)			
66999	Unlisted procedure, anterior segment, eye	BR		

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
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

			Follow Up Days	Anest
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
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)

			Follow Up Days	Anest
	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
	SCLERAL			
	REPAIR			
	(For excision lesion sclera, see 66130)			
67250	Scleral reinforcement (separate procedure); without graft	$200.00	30	8.0+T
67255	with graft (For repair scleral staphyloma, see 66220, 66225)	$210.00	30	8.0+T
67299	Unlisted procedure, posterior segment	BR		8.0+T

OCULAR ADNEXA

EXTRAOCULAR MUSCLES

			Follow Up Days	Anest
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) (List separately in addition to code for specific strabismus surgery)	$240.00	30	4.0+T
	(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
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)			

			Follow Up Days	Anest
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)			

MISCELLANEOUS

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)			
67550	Orbital implant (implant outside muscle cone); insertion	$240.00	30	4.0+T
67560	removal or revision	$240.00	30	4.0+T

			Follow Up Days	Anest
	(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)			
67850	Destruction of lesion of lid margin (up to 1 cm)	BR		3.0+T

			Follow Up Days	Anest
	(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	$100.00	60	3.0+T
67902	frontalis muscle technique with 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

			Follow Up Days	Anest
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	$20.00	60	3.0+T
	(For tubed pedicle flap preparation, see 15576; for delay, see 15630; for attachment, see 15650)			

			Follow Up Days	Anest
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

			Follow Up Days	Anest
	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

			Follow Up Days	Anest
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 (For resection of temporal bone, see 69535)	$500.00	90	6.0+T

			Follow Up Days	Anest
REMOVAL 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 (For combination with middle ear reconstruction, see 69631, 69641) (For otoscopy under general anesthesia, see 92502)	$400.00	180	3.0+T
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
69410	Focal application of phase control substance, middle ear (baffle technique)	BR		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	

			Follow Up Days	Anest
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 (For atticotomy, see 69601 et seq)	$200.00	30	3.0+T
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 (For middle fossa approach, see 69950-69970)	BR		3.0+T
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 (For planned secondary tympanoplasty after mastoidectomy,see 69631, 69632)	$400.00	180	4.0+T
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

			Follow Up Days	Anest
69632	with ossicular chain reconstruction, (eg, postfenestration)	$600.00	180	4.0+T
69633	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

			Follow Up Days	Anest
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	BR		4.0+T
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)			

			Follow Up Days	Anest
INTRODUCTION				
69930	Cochlear device implantation, with or without mastoidectomy	$380.00	180	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.)

-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.)

-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.)

-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.

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
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 materials	$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
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
71550	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)	$50.00
71551	with contrast material(s)	$500.00
71552	without contrast material(s), followed by contrast material(s) and further sequences (For breast MRI, see 76093 and 76094)	$500.00
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
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 (For pelvimetry, see 74710)	$20.00
72191	Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing (For CTA aorta-iliofemoral runoff, use 75635)	$254.00
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
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	$25.00
	(Do not report 76003 in addition to 73040)	
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	$25.00
	(Do not report 76003 in addition to 73085)	

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
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
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) (For CTA aorto-iliofemoral runoff, use 75635)	$500.00

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 (For CTA aorto-iliofemoral runoff, use 75635)	$254.00
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 (For procedure, see 49400) (For computerized axial tomography, see 72192 or 74150)	$19.00

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 (For procedure, see 43215, 43247)	$60.00

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
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 (For procedure, see 43260-43272 as appropriate)	$30.00
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation (For cholangiopancreatography (ERCP), see 43260-43272)	$36.00
74340	Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation (For tube placement, see 44500)	$20.00
74350	Percutaneous placement of gastrostomy tube; radiological supervision and interpretation	$30.00
74355	Percutaneous placement of enteroclysis tube, radiological supervision and interpretation (For procedure, see 44015)	$40.00
74360	Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretation (For procedure, see 43220, 43458)	$40.00
74363	Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation (For procedure, see 47510, 47511, 47555, 47556)	$80.00

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)	

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

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
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 (For selective angiography, additional visceral vessels studied after basic examination, see 75774)	$50.00
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
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
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 (For procedure, see 36500)	$100.00

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 (For infusion for coronary disease, see 92975, 92977)	$170.00
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion	$50.00
75900	Exchange of a previously placed arterial catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation (For procedure, see 37209)	$170.00
75901	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation (For procedure, use 36536, for venous catheterization, see 36010-36012)	$29.00
75902	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation (For procedure, use 36537, for venous catheterization, see 36010, 36012)	$27.00
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) (For procedure, see 37250, 37251)	$31.00
75952	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation (For implantation of endovascular grafts, see 34800—34808)	$200.00
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 (For implantation of endovascular extension prosthesis, see 34825, 34826)	$50.00
75954	Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, radiological supervision and interpretation (For implantation of endovascular graft, see 34900)	BR

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 (For procedure, see 37203)	$300.00
75962	Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation	$100.00
75964	Transluminal balloon angioplasty, 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	Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (Use 75968 in conjunction with code 75966) (For percutaneous transluminal coronary angioplasty, see 92982-92984)	$50.00
75970	Transcatheter biopsy, radiological supervision and interpretation (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)	$100.00
75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretatio	$180.00
75980	Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation (For introduction of percutaneous transhepatic catheter or stent for biliary drainage, use 47510, just for change of catheter only, see 47525)	$115.00
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 (For percutaneous nephrostolithotomy or pyelostolithotomy, see 50080, 50081)	$30.00

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	Transluminal atherectomy, 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	Transluminal atherectomy, visceral, radiological supervision and interpretation	$190.00
75996	Transluminal atherectomy, 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

MISCELLANEOUS 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 be neurolytic agent, see 64600-64680)

(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, per vertebral body; under fluoroscopic guidance	$25.00
76013	under CT guidance (For procedure, see 22520-22522)	$140.00
76020	Bone age studies	$15.00
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 (For injection of sinus tract, see 20501)	$15.00

76086	Mammary ductogram or galactogram, single duct, radiological supervision and interpretation	$30.00
76088	Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretation (For injection procedure, mammary ductogram, or galactogram, use 19030; to report as bilateral procedure, use 76088)	$40.00
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 (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)	$70.00
76098	Radiological examination, surgical specimen	$25.00
76100	Radiological examination, single plane body section (eg, tomography), other than with urography	$30.00
76101	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral	$45.00
76102	bilateral (For nephrotomography, see 74415)	$57.50
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 (For percutaneous radiofrequency ablation, use 47382)	$90.00

76370	Computed tomography guidance for placement of radiation therapy fields	$75.00
76375	Coronal, sagittal, multiplanar, oblique, 3 dimensional and/or holographic reconstruction of computerized axial tomography, magnetic resonance imaging or other tomographic modality	$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

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 (For partial coherence interferometry, use 92136)	$40.00
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

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.

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)	$25.00

(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))

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
76818	Fetal biophysical profile; with non-stress testing (MOMS $135.00)	$35.00
76819	without non-stress testing (MOMS $135.00) (For amniotic fluid index without non-stress test, use 76815)	$35.00
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 (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)	$60.00
76831	Saline infusion sonohysterography (sis), including color flow doppler, when performed (For introduction of saline or contrast for hysterosonography, use 58340)	$28.00
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)

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 (For procedure, see 36460, 59012)	$39.00
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 (For procedure, see 59015)	$32.00
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

MISCELLANEOUS

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) (For ultrasound guidance for open and laparoscopic radiofrequency tissue ablation, use 76940)	$285.00
76999	Unlisted ultrasound procedure (eg, diagnostic, interventional)	BR

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

DEFINITIONS:

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.

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 (Only one teletherapy isodose plan may be reported for a given course of therapy to a specific treatment area.)	$70.00
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
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, special particle beam (eg, electron or neutrons); 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. 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 99241-99263). 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

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

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 ***Miscellaneous Procedures***.

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
78160	Plasma radioiron disappearance (turnover) rate	$30.00
78162	Radioiron oral absorption	$30.00
78170	Radioiron red cell utilization	$50.00
78172	Chelatable iron for estimation of total body iron	BR

78185	Spleen imaging only, with or without vascular flow (If combined with liver study, use procedures 78215, 78216)	$70.00
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 (For sentinel node identification without scintigraphy imaging, use 38792) (For sentinel node excision, see 38500-38542)	$40.0
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) (For injection procedure, use 49427)	$40.00
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine	BR

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
78455	Venous thrombosis study (eg, radioactive fibrinogen)	$60.00
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
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	$166.00
	(Use 78496 in conjunction with code 78472)	
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
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: renal endoscopy, see 50559, 50578; cystotomy or cystostomy, see 51020; cystourethroscopy, see 52250; uretal endoscopy, see 50959, 50978)

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 53670, 53675)	
78760	Testicular imaging;	$40.00
78761	with vascular flow	$50.00
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

Diagnostic radiopharmaceticals;

A4641	Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified	BR
A4642	Satumomab pendetide, per dose	BR
A9500	Technetium tc-99m, sestamibi, per dose	BR
A9502	Technetium tc-99m tetrofosmin, per unit dose	BR
A9503	Technetium tc-99m medronate, up to 30 mci	BR
A9504	Technetium tc-99m apcitide	BR
A9505	Thallous chloride TL 201, per mci	BR
A9507	Indium-111 capromab pendetid, per dose	BR
A9508	Iobenguane sulfate I-131, per 0.5 mci	BR
A9510	Technetium tc-99m disofenin, per vial	BR
A9511	Technetium tc-99m depreotide, per mci	BR
A9512	Technetium tc-99m pertechnetate, per mci	BR
A9513	Technetium tc-99m mebrofenin, per mci	BR
A9514	Technetium tc-99m pyrophosphate, per mci	BR
A9515	Technetium tc-99m pentetate, per mci	BR
A9516	I-123 sodium iodide capsule, per 100 uci	BR
A9519	Technetium tc-99m macroaggregated albumin, per mci	BR
A9520	Technetium tc-99m sulfur colloid, per mci	BR
A9521	Technetium tc-99m exametazine, per dose	BR
A9522	Indium-111 ibritumomab tiuxetan, per mci	BR
A9524	Iodinated I-131 serum albumin, 5 microcuries	BR
A9526	Ammonia N-13, per dose	BR
A9528	I-131 sodium iodide capsule, per mci	BR
A9529	I-131 sodium iodide solution, per mci	BR
A9531	I-131 sodium iodide, per mci (up to 100 mci)	BR
A9533	I-131 tositumomab, per mci	BR
C1091	Indium 111 oxyquinoline, per 0.5 mci	BR
C1092	Indium 111 pentetate, per 0.5 mci	BR
C9102	51 sodium chromate, per 50 mci	BR
C9103	Sodium iothalamate 1-125 injection, per 10 uci	BR

Q3003	Technetium tc-99m bicisate, per unit dose	BR
Q3004	Xenon xe 133, per 10 mci	BR
Q3005	Technetium tc-99m mertiatide, per mci	BR
Q3006	Technetium tc-99m glucepatate, per 5 mci	BR
Q3007	Sodium phosphate p32, per mci	BR
Q3008	Indium 111-in pentetreotide, per 3 mci	BR
Q3009	Technetium tc-99m oxidronate, per mci	BR
Q3011	Chromic phosphate p32 suspension, per mci	BR
Q3012	Cyanocobalamin cobalt co57, per 0.5 mci	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

Therapeutic radiopharmaceuticals;

A9699	Supply of radiopharmaceutical therapeutic imaging agent, not otherwise classified	BR
A9517	I-131 sodium Iodide capsule, per mci	BR
A9523	Yttrium 90 Ibritumomab tiuxetan, per mci	BR
A9530	I-131 sodium solution per mci	BR
A9532	Iodinated I-125, serum albumin, 5 microcuries	BR
A9534	I-131 tositumomab, per mci	BR
A9600	Strontium-89 chloride, per mci	BR
A9605	Samarium sm 153 lexidronamm, 50 mci	BR

POSITRON EMISSION TOMOGRAPHY (PET)

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.

G0125	PET imaging regional or whole body; single pulmonary nodule;	$1,634.00
G0210	PET imaging whole body, full- and partial-ring PET scanners only; diagnosis, lung cancer, non-small cell	$1,634.00
G0211	initial staging, lung cancer, non-small cell	$1,634.00
G0212	restaging, lung cancer, non-small cell	$1,634.00
G0213	diagnosis, colorectal cancer	$1,634.00

G0214	initial staging, colorectal cancer	$1,634.00
G0215	restaging, colorectal cancer	$1,634.00
G0216	diagnosis, melanoma	$1,634.00
G0217	initial staging melanoma	$1,634.00
G0218	restaging melanoma	$1,634.00
G0219	melanoma for non-covered indicators	$1,634.00
G0220	diagnosis, lymphoma	$1,634.00
G0221	initial staging, lymphoma	$1,634.00
G0222	restaging lymphoma	$1,634.00
G0223	PET imaging whole body or regional, full- and partial-ring PET scanners only; diagnosis, head and neck cancer, excluding thyroid and CNS cancers	$1,634.00
G0224	initial staging head and neck cancer, excluding thyroid and CNS cancers	$1,634.00
G0225	restaging head and neck cancer excluding thyroid and CNS cancers	$1,634.00
G0226	PET imaging whole body; full- and partial-ring PET scanners only; diagnosis esophageal cancer	$1,634.00
G0227	initial staging esophageal cancer	$1,634.00
G0228	restaging esophageal cancer	$1,634.00
G0229	PET imaging; Metabolic brain imaging for pre-surgical evaluation of refractory seizures; full- and partial-ring PET scanners only	$1,634.00
G0230	PET imaging; Metabolic assessment for myocardial viability following inconclusive SPECT study; full- and partial-ring PET scanners only (should continue to be billed following an inconclusive SPECT)	$1,634.00
G0252	PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (eg, initial staging of axillary lymph nodes)	$1,634.00
G0253	PET imaging for breast cancer, full and partial-ring PET scanner only; staging/restaging of local regional recurrence or distant metastases, i.e., staging/restaging after or prior to course of treatment	$1,934.00
G0254	evaluation of response to treatment, performed during course of treatment	$1,934.00
G0296	Pet imaging, full and partial ring pet scanner only, for restaging of previously treated thyroid cancer of follicular cell origin following negative I-131 whole body scan	$1,634.00
G0336	Pet imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs fronto-temporal dementia.	$1934.00
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

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